# HEALTH, WELFARE AND DEVELOPMENT IN RURAL AFRICA

## Catholic Medical Mission and the Configuration of Development in Ulanga/Tanzania, 1920-1970

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Die Dekanin
Prof. Dr. Barbara Schellewald

**"Mission Dispensary at Ifakara"**

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Map of the United Republic of Tanzania

shape roughly showing area of Ulanga

open source UN map[1]

shape added by Marcel Dreier

[1] http://en.wikipedia.org/wiki/File:Un-tanzania.png

# Abbrev.

| | |
|---|---|
| ADO | Assistant District Officer |
| B. / Br. | Bruder (Brother / formerly a Capuchin Monk who was not an ordained priest, now all Capuchins are called Brother) |
| CHD | Community Health Department |
| CSM | Cerebrospinal Menengitis |
| DftZ | Dienst für technische Zusammenarbeit (Swiss Development Cooperation) |
| DMO | District Medical Officer |
| DM(S)S | Director of Medical (and Sanitary) Services of Tanganyika Territory |
| DO | District Officer |
| DSM | Dar es Salaam |
| E.A. | East Africa |
| E.P. | Eastern Province (of Tanganyika) |
| MATC | Medical Assistants Training Centre, Ifakara |
| MCH | Maternal and Child Health (sometimes also Mother and Child Health) |
| MO | Medical Officer |
| MOH | Ministry of Health |
| N.A. | Native Authorities |
| OPD | Out Patients Department |
| P. | Pater (Father / Priest) |
| PC | Provincial Commissioner |
| PHC | Primary Health Care |
| SDC | Swiss Development Cooperation |
| SFDDH | St. Francis Designated District Hospital |
| SFH | St. Francis Hospital |
| SKMV | Swiss Catholic Association for Missionary Medicine |
| Sr. | Sister |
| RAC | Rural Aid Centre |
| TANU | Tanganyika African National Union |
| TAZARA | Tanzania Zambia Railway |
| TB | Tuberculosis |

# Acknowledgements

Basel, April 2019

Over the last 4 years, I have found little time to revisit this text and the material it presents. The main reason is that I myself entered the world of development practitioners at the very time of completing and submitting this thesis. From that moment onwards, African activists helped me to engage with the ideas of development, especially rural development, in diverse ways, and I thank them for allowing me to participate in their struggle for rights and better lives. I decided to rework the introduction as the only substantial change from the version submitted in August 2014, making the argument about the role of power and the trajectories of (religious) institutions in the history of development a bit more general. I am grateful to Kate Greenberg, Wood who assisted me with her language and orthography skills.

I also feel that an acknowledgement of the university as an institution has become necessary. The University of Basel provided the space for research with the potential to produce knowledge that is relevant to our societies. Over the last couple of years, working more and more on the fringes of this scientific institution, I have developed some nostalgia for the networks of the university and the access they provided to research time, knowledge and the fruits of scientific production. Towards the end of this thesis, the reader will encounter similar nostalgia for (public) services rendered by health institutions as an important element of the history of development in rural Africa. I concluded that it would be best to publish the material of this thesis online and with the fewest possible barriers to public access.

Patrick Harries was the key figure for me in these networks and his passing away less than a year after submitting this thesis has left a deep loss in my intellectual life.

Basel, August 2014

While researching and writing this thesis, I accumulated a heap of papers and at least as many debts to people who guided, assisted, and supported me, sharing their histories and spare time with me.

Patrick Harries stimulated and steered the project and accorded me freedom in my intellectual work. He constantly motivated me to expose my ideas to critical discussion and urged me to assume control over text and subject matter in practical ways. Supriya Guha supported the writing in an outstanding manner. As I struggled with the English language, she read and edited almost every single sentence of this thesis, and her support encouraged me to

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Richard Sambaiga, Vendelin Tarmo, Karin Gross, Benjamin Brühwiler, Jana Gerold and Melissa Graboyes all travelled with me in Tanzania, showed me ways of getting in touch with Tanzanian life, and shared research contacts with me. I also received help and input on how to organize research in Kilombero and Ulanga from Jamie Monson, Maia Green, Lorne Larson, and the staff of the Ifakara Health Institute. In Ifakara, Ruaha and Mahenge, Phemy Muhaku, Zacharias Likopa, George Mwambeta and Jonathan Chitalula worked with me, and if it weren't

for their skills as ambassadors, mediators, and translators, I wouldn't have found all the knowledgeable people to talk to. Elisabeth Rotzetter, who directs the activities of Solidarmed in Tanzania, was also a great practical supporter of my fieldwork in Tanzania. Solidarmed in Luzern were no less friendly, and opened their offices for this research.

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Marita Haller was central when it came to getting my hands on sources. She knew the relevant archives for the history of the Swiss Capuchin's Mission and connected me to these places in the friendliest manner. Not least, she introduced me to Br August Mullis, Br Florian Brantschen, and the late Meinhard Inauen in Dar es Salaam. I am grateful to all the archivists who helped me along the way, especially in Baldegg, Luzern, Olten, Basel, Bern, Würzburg, and Dar es Salaam.

Costech approved my project and issued a permit to conduct research in Tanzania. KFPE, FAG Basel, SAMW, Rudolf Geigy Stiftung, the Forschungsfonds of the University of Basel and SNIS all contributed financially to the project that framed my research. The single most important funder was the Swiss National Science Foundation. Without these sponsors of academic research, this thesis would not have been produced.

Nor could this kind of research have been done without those who shared their history with me. The names of those who did so in formal ways are all listed at the end of this thesis. In Switzerland, I spent more hours with Edgar Widmer and Per Schellenberg than the list of interviews can represent. Irmengard and Carl Schöpf received me in their home in Zams back in 2007, which was really a foundational moment for this research. This thesis is also dedicated to the memory of Sister Sandra Stich, born in my father's village, who died in Dar es Salaam, and who shared her perspective of Tanzania during two memorable days in 2008. In Ifakara, Manu Haridas told me many stories of the old Ifakara and its Indian community, and Ally Daraja explained the life and aspirations of the younger generation.

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*"Let us accept a minimal definition [of Development] in terms of its functional implications, i.e. a conscious and deliberate intervention into the empirical status quo ante, a purposive action to alter sets of conditions, whether these be (in the most common referent of the term) economic, as in attempts to improve the food supply; or in any other institutional area of human life, as in the establishment of new settlement patterns, educational systems, forms of governance, or whatever."*[1]

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*„Like rural people the world over, Ulanga's farmers strive to participate in development interventions on their own terms in a bid to bypass the very constraints which inhibit them."*[2]

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*"The Catholic Church has always been in the forefront of the development of this country, and especially in extensive works of practical charity to liberate our country form the three great enemies, poverty, ignorance and disease."*[3]

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*"Path dependency has become commonplace in the policy world; to a historian it is in operational terms another word for history [...]"*[4]

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[1] Charles C. Hughes et al., *Disease and 'Development' in Africa*, in Social Science and Medicine, 1970, p. 444.
[2] Maia Green, *Participatory Development*, in Critique of Anthropology, 2000, p. 75.
[3] The Minister of Health of Tanzania at the time and former Catholic Mission Medical Doctor Leader Stirling in a letter to Edgar Widmer, President of Medicus Mundi Internationalis and former doctor at St. Francis Mission Hospital in Ifakara. PA Widmer L. D. Stirling, *Letter to E.Widmer. DSM 05.07.1980*.
[4] Charles E. Rosenberg, *Anticipated Consequences*, 2006, p. 30 fn 17.

**Abbildung 1 "Bwana Mganga" and the missionary[1]**

The caption reads:

> "Br. Ferdinand. We met this fellow at Jumbe Pembe's. From the Boma at Kibata this lad travels accompanied by his carrier temporarily into the bush und he dispenses medicine to the Africans for the most common diseases, in the majority of cases an ointment for the ugly and widespread disease *Buba*, a cancer-like affliction of the skin. I was unable to urge the man carrying the medical basket to remain standing. Terrified he ran off."

The "Bwana Mganga" must have been involved in a Government campaign against Yaws.

[1] Fotograph in the collection of PSKO most likely shot by Wolfram Meyer*Der Bwana-Mganga (Arzt)*.

# Introduction ■ Mission, Health, Institutions, and the History of Development

Development as an idea and practice has configured African societies in the 20th century in ways that we are yet to fully appreciate. Notably, some of the most incisive interventions into local societies happened as 'development' and spanned the colonial and postcolonial era. For local societies, development defined points of reference, created relevant institutions, and produced subjectivities, entitlements and governmentalities.

This thesis adds to a growing field of research on the history of development, and does so by discussing the role of medicine and health institutions in rural Africa.[1] Based on a case study of the Catholic Mission in the Ulanga and Kilombero districts of southern Tanzania, my research analyses changing forms of health care and health governance and how these changes were framed by moral discourses about charity, welfare and development in the period from roughly 1920 to the 1970s. This dissertation also shows how institutions with a religious background not only moulded social figurations, but also referred more or less explicitly to development.[2]

Institutions were central to development because of these qualities, for their ability to symbolize and organize a process of 'progress'. But the examples of failures of 'imported' institutions and development programmes and projects are legion, and the whole idea of development has become deconstructed.[3] This does not mean at all that ideas and practices – or

[1] For a recent debate on the historiography of development, see Joseph M. Hodge, *Writing the History of Development*, in Humanity Journal, 2016. Plus the roundtable discussion between a number of eminent historians of development discuss this text in the same online journal. Essential texts during my research were Frederick Cooper, *Writing the History of Development*, in Journal of Modern European History, 2010; Marc Frey et al., *Writing the History of Development*, in Contemporary European History, 2011; Helen Tilley, *Africa as Living Laboratory*, 2011; Ruth Prince, *Situating Health*, 2014.

[2] Figurations describe a dynamic process of interrelated social positionality as dynamic constellations between segments of societies. Norbert Elias explained their dynamism with a balldance. The genealogy of development figurations has been incisive not only in local societies, but fundamental to the configuration of social relations on a global scale. Because I am not writing a sociology of development, I will mostly use the term 'configuration' to describe dynamic networks of interdependent action.

[3] For a philosophical and political critique of development: Wolfgang Sachs, ed. *Development Dictionary*, 1992. Arturo Escobar, *Encountering Development*, 1995. This is part of what is described as a post-development theory. Beyond these studies that often base their arguments firmly on historical or anthropological studies in the global South, any Google search

expectations – of development have vanished, nor have most of the institutions that were born through development. On the contrary, expectations, practices and institutions shape the discourse and programmes of African statehood and structure the daily struggle of Africans for humane livelihoods. This thesis looks at the history of some of these institutions and the changing configurations that were created in the drive for progress and development.

The genealogy of a modernist health system in Ulanga, a rural area of Tanzania, is at the core of the narrative. It originated in a project focused on the history of a particular mission hospital, the St. Francis Hospital in Ifakara, started by Catholic missionaries organized by the Swiss province of the Capuchins.[4] The Catholic mission has been a major actor in Ulanga since 1921.[5] Here, as in large parts of rural Africa, missionary health services laid the institutional foundations on which modern health systems would grow. Translocal processes formed that particular hospital and the rudimentary modernizing health system surrounding it. The rural health system in Tanzania remained connected with local and global practices that entangled societies over space and time.[6]

Medical mission institutions did not only extend to the medical marketplace: they also provided a site in which colonial welfare and access to health and care was negotiated and where the moral and social consequences of new bodily practices were discussed. Dispensaries and hospitals were therefore sites for cultural encounters and debates about modernity and development and its moral and political implications.[7] Thus, while missions were about religion, they also proved to be deeply involved in the secular.[8]

This dissertation discusses how ideas of social order and practices of social work that were grounded in religious institutions have contributed to the modern world, a world that was, both in the 19th century and into the era of development, "still much more religious and already much more global" than we tend to think.[9] Secular issues matter wherever and whenever human

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quickly generates a lot of links to more general political debate about the impossibility of international development, which often claims its 'uselessness' or 'death'. An interesting entry point into this debate could be served by Dambisa Moyo, *Dead Aid*, 2009. In debates about the useful or useless character of development policies, historians are often absent: Marc Frey et al., *Writing the History of Development*, in Contemporary European History, 2011, p. 218.

[4] This dissertation is the result of a larger research project called "History of Health Systems in Africa" which was led by Patrick Harries and Brigit Obrist, with Piet van Eeuwijk, Pascal Schmid, Hines Mabika and myself as staff. See the joint working paper under https://snis.ch/project/a-history-of-health-systems-in-africa.

[5] The importance of the Catholic Mission for Development in this particular area has been noted in Maia Green, *Priest, Witches and Power*, 2003, p.142. Eduard Desax, *Entwicklungshilfe*, 1975. Lorne Larson's dissertation remains essential to the historiography of this region: Lorne Larson, *History of Mahenge*, 1976.

[6] Lukas Meier, *Swiss Science*, 2014.

[7] Julie Livingston, *Debility and the Moral Imagination*, 2005, pp.112, 133; Nancy Rose Hunt, *Colonial Lexicon*, 1999; Stacey Langwick, *Bodies, Politics and African Healing*, 2011; Osaak A. Olumwullah, *Dis-ease in the Colonial State*, 2002; Walima T. Kalusa, *Disease and the Remaking of Missionary Medicine*, 2003.

[8] Patrick Harries et al., eds., *Spiritual in the Secular*, 2012; Gerald Faschingeder, *Missionsgeschichte als Beziehungsgeschichte*, in Historische Anthropologie, 2002; Rebekka Habermas, *Mission global*, 2014; Siegfried Weichlein et al., eds., *Der schwarze Körper als Missionsgebiet*, 2016.

[9] Rebekka Habermas, *Globale Netze des Religiösen*, in Historische Zeitschrift, 2008, p.51; Philipp Lepenies, *Lernen vom Besserwisser*, 2009, pp. 118, 131; René Holenstein, *Was kümmert uns die Dritte Welt*, 1998. There is a string of research on 'religion in development', much of it referring to Oscar Salemink et al., *The development of religion / the religion of development*, 2004.

souls are embodied in flesh, and they mattered for missionaries, who brought not only salvation to souls, but were sent to establish the church as the social body and order of their religion. And when social order needed to conform to and express morality, then ideas about power and the state, the rights and duties of subjects, science and medicine, and the contribution of all these things to wealth and progress became part of social practices and institutions.

At first glance, it seems ironic that agents of a conservative, religious movement became the major drivers of modernization and established central pillars of the welfare state.[10] But missions indeed worked hard to install the institutions through which the humanitarian narrative blossomed and pushed with great impetus the ideas of the benevolent or humanitarian empire.[11] African Catholics came to see their religion, including its material and institutional aspects, such as hospitals and schools, as a driver of progress, and developed an identity of being modern.[12] Modern health institutions delivered not just efficacious pills and injections, but also a moral teaching about care and compassion as basic components of a Christian-bourgeois ethic that 'saves', 'helps', and 'assists' those who are not well.[13] This morality was part and parcel of the Catholic style of development in Kiswahili, *maendeleo*. Even before *maendeleo* became programmatic for the postcolonial nation, a Christian modernity had included altruistic healing, partly delegated to outsiders, as development, in a move that interwove "the themes of Christian caring, medical humanism, colonial development and welfare policy" with modernization and respectability.[14] What is essential to us is that, in the context of mission, missionaries and Africans built a body of knowledge that consisted to a large degree of practical knowledge about how to craft and run institutions that could 'save' and transfer values and knowledge.

The making of this involvement of the church in development takes us on a journey into the long history of new regimes of social care, where religious actors, before the 'age of development', supplemented attempts of colonial administrators to establish even the thinnest of welfare systems.[15] This dissertation shows development *avant la lettre* at play in the context of missionary institutions and argues that not only health systems, but also the figurations of

[10] Weichlein/Ratschiller have described this as a process of "secularization through religion", Siegfried Weichlein et al., eds., *Der schwarze Körper als Missionsgebiet*, 2016, p. 29.
[11] Ellen Fleischmann et al., eds., *Transnational and Historical Perspectives*, 2013; Tony Ballantyne, *Humanitarian Narratives*, in Social Sciences and Missions, 2011; Norman Etherington, *Missions and Empire Revisited*, in Social Sciences and Missions, 2011, p. 178; Michael Worboys, *Colonial World as Mission and Mandate*, in Osiris, 2nd Series, 2001.
[12] Katherine Snyder has shown the dichotomy between the 'traditional' on one hand, and the 'modern' and 'cosmopolitan' on the other. This dichotomy involved complex cultural politics that cut across kin. Conversion to Catholicism was seen as an important step towards *maendeleo*. Katherine A. Snyder, *The Iraqw*, 2005, pp. 6, 18, 140. Maia Green's research points in the same direction: Catholic faith and institutions were considered by the population as 'Western' and modern, and also connected to the state, while progress coupled at the same time with a more individualized advancement: Maia Green, *Priest, Witches and Power*, 2003; Maia Green, *Participatory Development*, in Critique of Anthropology, 2000; Peter Pels, *Politics of Presence*, 1999; Oswald Masebo, *Society, State and Infant Welfare*, 2010, p. 152.
[13] Christa Schnabl, *Gerecht sorgen*, 2005; James Ferguson, *Expectations of Modernity*, 1999, pp. 212-218.
[14] Steven Feierman, *Popular Control*, 1986, p. 212; Michael Worboys, *Colonial World as Mission and Mandate*, in Osiris, 2nd Series, 2001, p. 207; Robert Ross, *Status and Respectability*, 1999. On *maendeleo* see footnote 46.
[15] The age of development is often associated with post WWII doctrines: Gilbert Rist, *Development as a Buzzword*, in Development in Practice, 2007; Wolfgang Sachs, ed. *Development Dictionary*, 1992. But see footnote 1.

development and the political field of developmentalism should be traced back to the transnational history of these secular religious institutions.[16]

## Historicize Cultures and Politics of Health and Healing

The pages of this dissertation contribute to a growing body of research on the history of mission medicine.[17] Mission and medicine shall, however, take us further into the fields of health, knowledge and development. Health depends on a great many factors and is the product of complex social interactions. Historians of medicine (in Africa) have developed a sensibility for these complexities and seek to write 'a total social history', showing health as a product at the intersection of politics, kinship relations, religion, trade, farming, sexual life and more.[18]

The approach that guides this social history of development is Frederick Cooper's memento about the need to subject all grand terms to criticism: "One can [… ] write about large-scale, long-term processes without overlooking specificity, contingency, and contestation". This is possible if one looks closely at "who intervenes, for what reasons, through what relationships, and to what effect". Along with Megan Vaughan's reminder that interventions should be looked at with an interest in how they were "read by those at whom they were directed", Cooper's call is taken as a guide for the chapters that follow.[19] Drawing on a range of postcolonial contributions to the history of medicine in Africa, I try to take up the call to write a social history which is sensitive to culture and knowledge and localizes and historicizes its constituents.[20]

[16] 'Developmentalism', to me, is a discourse that puts promises and practices of development at the centre of state, institutions or actions. Leander Schneider, *Developmentalism*, 2003.

[17] John L. Comaroff et al., *Revelation and Revolution II*, 1997, chapter 7: The Medicine of God's Word; A.F. Walls, *Heavy Artillery of the Missionary Army*, 1982; Christoffer H. Grundmann, *Sent to heal*, 2005; Walter Bruchhausen, *Medizin zwischen den Welten*, 2006, in particular parts 3 and 4 from page 293 onwards; David Hardiman, ed. *Healing Bodies*, 2006; Pascal Schmid, *Medicine, Faith and Politics*, 2018. Recent work on Tanzania includes, in addition to Bruchhausen's, Charles M. Good, *Steamer Parish*, 2004; Michael Jennings, *Healing of Bodies, Salvation of Souls*, in Journal of Religion in Africa, 2008; Barbra Mann Wall, *Into Africa*, 2015.

[18] Steven Feierman et al., *Social Basis - Introduction*, 1992. Together with Bruchhausen, the best introduction to health policies and its historiography is John Iliffe, *East African Doctors*, 1998. A social historical approach to health and medicine is not a new initiative. When at the end of the 1970s, health had been firmly put on the historiographical agenda in Africa, it was established that colonial rule and global entanglements had heavily impacted on the health of Africans and on the ecology of diseases in Africa. K. David Patterson et al., *Disease Factor*, 1978, pp. 3, 11, 15-16. For recent introductions to the historiography of health and disease in Africa, see Ryan Johnson, *Historiography of Medicine in British Colonial Africa*, in Global South (sephis e-magazine), 2010; Lyn Schumaker, *History of medicine in sub-saharan Africa*, 2011; Nancy Rose Hunt, *Health and Healing*, 2013; Ruth Prince, *Situating Health*, 2014. Historians of Tanzania contributed much to these new social and political histories of health and colonial (and even of missionary) health services, as well as to the argument that 'development' had impacted on health in both conducive and destructive ways. The argument about (colonial) development was made with many examples from Tanzania by Charles C. Hughes et al., *Disease and 'Development' in Africa*, in Social Science and Medicine, 1970; Helge Kjekshus, *Ecology Control and Economic Development*, 1996 [1977]; Meredeth Turshen, *Impact of Colonialism*, in International Journal of Health Services, 1977; D.E. Ferguson, *Politcal Economy of Health and Medicine*, 1980.

[19] Frederick Cooper, *Concept of Globalization*, in African Affairs, 2001, p. 202; Frederick Cooper, *Writing the History of Development*, in Journal of Modern European History, 2010, p. 20; Megan Vaughan, *Health and Hegemony*, 1994, p. 173.

[20] Stacey Langwick, *Bodies, Politics and African Healing*, 2011. See also the work of Warwick Anderson. For example, Warwick Anderson, *Postcolonial histories of medicine*, 2006.

As a history of the knowledge and practices of development and medicine, this dissertation approaches its subject from local, transnational and global angles, with an interest in a) mission and medicine in the context of the engineering of social order and b) the political, cultural and everyday negotiations of development in the colonial and late colonial periods.

## Medical Missions and the Engineering of Social Order

Mission, medicine and development often came in the form of power-laden interventions into local social order. I approach the interplay of power, moral economies, and development practice, and how social order is constructed out of the interaction of a Catholic mission with developmentalist biopower in the 20th century.[21] That the state and missions felt a common responsibility for the welfare of Africans and expressed a need to "transform the poor into the assisted" is not only the result of faith and religious calling, but also the product of a specific history of governing. The government of 'needs', 'gaps', and 'progress' produced interventions that anchored mechanisms and institutions of development that were able to turn people into assisted subjects.

Medical missions, however, were more than a cog in the machine of one-dimensional colonial power. They were part of complex negotiations about moral economies – negotiations about values, that touched on issues of distribution, reciprocity and fairness – which evolved in the context of the civilizing mission and the exploitation of colonial subjects. In African societies, development practices were intricately linked to debates about social health, issues of belonging, and the claims of peasants for the 'right to subsistence' and physical survival. Still, colonial development in general gave little value to these African articulations of moral economies.[22] With this background, my work engages with the history of the 'benevolent empire' and its elements of governmentality that span the pre- and the postmodern, the colonial and the postcolonial.[23]

The idea of the progress of civilizations and of civilization's progress lies at the core of the systems of knowledge and practices of government from which the idea about the need for development and the benevolence of upliftment arose, and through which the colonial state

[21] Tania M. Li, *Will to Improve*, 2007; David Ludden, *India's Development Regime*, 1992. A helpful introduction to historiography of medicine and power is the introduction in: Marion Wallace, *Health, Power and Politics*, 2002.
[22] Steven Feierman, *Peasant Intellectuals*, 1990; James C. Scott, *Moral economy of the peasant*, 1976, pp 176-177; Norbert Götz, *Moral Economy*, in Journal of Global Ethics, 2015. See also a research programme at the Max Planck Institute and others running when this thesis was almost completed:
https://www.mpib-berlin.mpg.de/de/forschung/doktorandenprogramme/imprs-moral-economies. On the huge importance of moral economies for Catholism in Switzerland in the mid first half oft he 20th century:Aram Mattioli et al., *Katholizismus und Soziale Frage*, 1995.
[23] Tania M. Li, *Will to Improve*, 2007.

partly exerted its power.[24] The moral urgency for a civilizing mission, and the colonial modernity which this idea of progress created, was not only essentially paternalistic and eurocentric; it had also grown from roots that were related to the motives of religious mission, driven by the will to lift humanity out of heathenism.[25] Thus, although the very notion of the civilizing mission captures well the kinship of the mission project with modernization, and although the theory of secularization in European history has become refuted, the legacies of religious entanglements and pastoral forms of governmentality for the history of the developmentalist states in Africa are still underexplored.

Foucault argued that 'pastoral power' – a concept he later reworked into his notion of 'biopower' – had been devolved from religious to non-religious actors, in particular to the modern state, from about 1800. Pastoral power is a paternalist mode of leadership and disciplined behaviour that organizes subjects' lives and survival, rather than their legal relationships or territory.[26] It is wielded by a shepherd who controls people, keeps his flock healthy and strong, and assures the salvation of subjects through acting in individualized relationships. Wielding power felt like a 'duty' to the shepherd, often a charismatic figure, who felt part of a complex economy of responsibility.[27] Ever since, the imperfect transformation of the pastoral into a rights-based system – and the existence of personal and clientelist forms of organization in the modern world – undergirds both development practice and modern African states, in which many still depend on the hope that a powerful person will act as a catalyst to their personal development.[28]

In this dissertation, I look at how the health needs of rural Africans was a domain where colonial and postcolonial development policies and administrative practices enacted pastoral power in the framework of humanitarian interventions, and, more importantly, in health systems. This modernized pastoral developmentalist governmentality had its origins in the 1920s, when 'interventionist colonialism' took off.[29] This was also the time when the Swiss

[24] Lucien Febvre, *Civilisation*, 1929; Michael Schubert, *Der schwarze Fremde*, 2003; Jürgen Osterhammel, *Great Work of Uplifting Mankind*, 2005; Philipp Lepenies, *Lernen vom Besserwisser*, 2009.
[25] Rebekka Habermas, *Mission global*, 2014, p. 668 with an example of F. Engels.
[26] Arturo Escobar, *Encountering Development*, 1995, p. 22; Philippe Büttgen, *Théologie politique et pouvoir pastoral*, in Annales: Histoire, Sciences Sociales, 2007; Michel Foucault, *Subject and Power*, in Critical Inquiry, 1982, pp. 783-784; Michel Foucault, *Omnes et Singulatim*, in The Tanner Lectures on Human Values, 1979, pp. 228-229, 235. Foucault's terms are accessibly explained in Michael Ruoff, *Foucault Lexikon*, 2007, entries for Pastoralmacht, Biomacht und Biopolitik. On paternalism and maternalism in development: Maria Eriksson Baaz, *Paternalism of Partnership*, 2005; Andrew Hartnack, *Ordered Estates*, 2016. For the debate on Humanitarianism see Erica Bornstein et al., *Anthropology of Humanitariansm*, 2010.
[27] Nietsche has an interesting figure, the ascetic priest in the third part of his *Genealogie der Macht*, 1887.
[28] Maia Green, *Development State*, 2014, p. 10; Frederick Cooper, *Possibility and Constraint*, in The Journal of African History, 2008, 167-196. In broader terms, think of the works of Achille Mbembe, Jean-François Bayart or Patrick Chabal. Such institutions also drew on forms of power that Max Weber discussed as charismatic and patrimonial systems of leadership and domination in his Max Weber et al., *Wirtschaft und Gesellschaft: Grundriss der verstehenden Soziologie*, 2002. These personal and clientelist forms of organization are part of the modern world, and are a central object of criticism of development as well as of the modern African state in the era of neo-patrimonialism more broadly.
[29] Helen Tilley, *Africa as Living Laboratory*, 2011, introduction; Joseph Morgan Hodge, *Triumph of the Expert*, 2007; Christophe Bonneuil, *Development as Experiment*, in Osiris, 2000.

Capuchins started to engage in Tanganyika. We can therefore take Ulanga as a particular case that helps to understand the modernization of pastoral power.

In the 1930s, Swiss missionaries in Tanganyika saw themselves as part of the civilizing mission and identified a mandate for Switzerland. They felt that it was a "worthy task for a developed people", as the Swiss liked to consider themselves, "to develop its own will to bring a more cultured life and decent manners to the African race." The thirst of the Catholic Church for expansion was not only morally sound, they held, but a "holy duty: The African has a right to Christian Mission and religious guidance just like any European people." The civilizing mission of the Swiss Mission was regarded, as early as the 1930s, as an 'international obligation' directed at correcting the ruthless exploitation of Africans by colonial powers.[30] Development, in their view, was linked to the idea of emancipation, from the burden of unfair and exploitative rule of men over men, and men over women. Increasingly, development could even be seen as the road to decolonization.

But expections about global citizenship or equal welfare within a world of nation states remained overwhelmingly unrealized, and the case of Ulanga highlights some of the anti-modernist and undemocratic institutional roots of development discourse and the developmentalist state. Continuities in pastoral power created a figuration that both connected *and* divided the people entangled in mission or in international development.[31] In the development configurations I look at, a large-scale moral tale of development distortingly bonded those who 'bring' or 'aid' development with those who are 'developing'. Today, the needy subject of intervention in the development figuration is called the 'partner', expressing their active part. Indeed many people have "learnt to be a development category" and have established "connections with the world from which development emanates".[32] Therefore, it remains essential to research the "complexity of engagement of Africans with imported [sic!] institutions", as phrased by Cooper[33], and, increasingly, with the supremacy of dominant theories of development over social institutions and social order.

As the the civilizing mission went out of fashion from the mid-20th century, the idea took root that technological transfer rather than cultural change was necessary and opportune. Development sometimes became so outwardly technical that it became a machine that erased the politics that really drove it. Moral tales and bureaucratic organization interplayed in curious

[30] *An die Missionsfront*, in Missionsbote der Schweizer Kapuziner in Afrika, 1935; G., *Fürs Schweizerland oder für Heidenland?*, in Missionsbote der Schweizer Kapuziner in Afrika, 1933. For an argument that it was the Catholic minority in Switzerland who pushed a humanitarian "internationalism": A Gigon, *Avant Propos*, in Katholisches Missionsjahrbuch der Schweiz, 1935.

[31] Walter Rodney, *How Europe underdeveloped Africa*, 1981 [1972]; Stacy Leigh Pigg, *Found in Most Traditional Societies*, 1997, p. 267; Henrietta L. Moore et al., *Cutting Down Trees*, 1994, pp. 115, 127; Frederick Cooper, *Conflict and Connection*, in The American Historical Review, 1994, p. 1534.

[32] Stacy Leigh Pigg, *Found in Most Traditional Societies*, 1997.

[33] Frederick Cooper, *Conflict and Connection*, in The American Historical Review, 1994, p. 1534.

ways to produce development as a 'technical game', with complex structures of power, paternalism and exclusion.[34] The history of Tanzania's early independence developmentalist ideology, *ujamaa*, is an important example. *Ujamaa* socialism, Tanzania's post-independence development credo, sought to access the domain of the moral.[35] At the same time, *ujamaa* tended to be quite authoritarian.[36] The public debates about *ujamaa* development, about being a good national comrade (*mwananchi*), as well as the public chastising of 'bloodsuckers' and other morally unsound figures, highlighted the struggles of Tanzanians to insert their life-worlds into a larger discourse about being developed - a moral discourse that actively formed around ideas about virtue and respectability.[37] It soon became apparent that Tanzanians found many alternative ways to modernize and develop their economic lives and give meaning to the nation. The history of *ujamaa* indicates that we must not overstate the anti-politics effect of development practices. Large-scale, high modernist development did not necessarily anchor the state very strongly in the local context.[38] Rather, we must look at governmentality's capillary and complex ways of shaping the configurations of development.

Africans not only navigated the streams of paternalism which were deeply rooted in colonial missionary institutions; they also discussed the institutions and worked on integrating some of the more valuable 'imported' institutions into the fabric of society. Unintended or unannounced outcomes and effects that lie outside the official systems of benign and humanitarian economic and social development show not only the failures of *institutionalisierte Besserwisserei* (institutionalized wise-guy-ism) of development.[39] As we look at the productivity of development in the context of networks established in pastoral power formations, we can glimpse beyond 'better' knowledge and begin to perceive alternative roads and emancipative potential that people saw in development institutions and practices. This dissertation thus adds to the perspectives that Tania Li presented in her "will to improve", where she reintroduces subaltern politics into the question of developmentalist governance.[40] When development and health interventions left their preset configurations and intended trajectories and became

[34] Frederick Cooper et al., *International Development - Introduction*, 1997, p. 1; Richard Rottenburg, *Far-fetched facts*, 2009; Constanze Pfeiffer, *Erfolgskontrolle*, 2007; Maria Eriksson Baaz, *Paternalism of Partnership*, 2005.

[35] Goran Hyden, *Beyond Ujamaa*, 1980, chapter 4; I. N. Kimambo, ed. *Contemporary perspectives on African moral economy*, 2008, with reviews of the debate in the chapters by Kazuhiko Sugimura and Tadasu Tsuruta, pp. 3-15, 35-52; Julius Kambarage Nyerere, *Ujamaa - The Basis of African Socialism [April 1962]*, 1968; Maia Green, *After Ujamaa*, in Social Analysis, 2010, pp. 23, 31n11.

[36] On the issue of top-down development ideology of the elite see e.g.: Michael Jennings, *Run While Others Walk*, in The Journal of Modern African Studies, 2003; Leander Schneider, *Freedom and Unfreedom*, in Canadian Journal of African Studies / Revue Canadienne des Etudes Africaines, 2004.

[37] Emma Hunter, *Revisiting Ujamaa*, in Journal of Eastern African Studies, 2008. For a study from Ulanga, with an interesting annex with results from essays about development by Ulangan pupils born in the early 1950s, see: Noa Vera Zanolli, *Education Toward Development*, 1971, pp. 203ff. Jamie Monson, *Africa's Freedom Railway*, 2009, chapters 4 and 5; Jamie Monson, *Defending the People's Railway*, in Africa, 2006; Aili Mari Tripp, *Changing the Rules*, 1997, in particular p. 11-12.

[38] Ujamaa villagization in Tanzania is a case in point, see James C. Scott, *Seeing like a state*, 1998; Leander Schneider, *High on Modernity*, in African Studies, 2007; Goran Hyden, *Beyond Ujamaa*, 1980.

[39] James Ferguson, *Anti-Politics Machine*, 1990; Philipp Lepenies, *Lernen vom Besserwisser*, 2009; Richard Rottenburg, *Far-fetched facts*, 2009.

[40] Tania M. Li, *Will to Improve*, 2007, pp. 26-28.

bricolages on slippery and complex local terrain – and it seems they invariably did – a space not only for navigation, but for negotiation opened.

## Mission Medicine as Site of Contestations

Colonial governmentality used interventions into bodily regimes as a key aspect of social engineering, and medicine provided some of the most incisive technologies for this.[41] Through medical practices, social order was transformed into habitus. But this was never a simple question of decreed 'lifestyles'. It was always an intensely political field.[42] Medical practices were the objects and expressions of political struggles, not least because the legitimacy of social orders was often assessed by their ability to produce health.

African societies understood maladies as a gauge for social and moral imbalances. As a consequence, medicine served as an instrument to reestablish social order and produced experiences of belonging and imaginations of the community.[43] Individuals felt considerable social pressure to undergo specific rituals or consume certain medicines. An obvious example is witchcraft cleansing rituals, where Christians explained to missionaries that they were threatened with forceful expulsion from the area if they resisted taking part.[44]

We shall see that mission medicine threw itself into this contest of medical and bodily practices and feted the progress of modern technology, effectively entering into competition with other providers of modern medicine. As I argued above, missionaries were not afraid to be heralds of modernization, because in the colonial environment of the civilizing mission, charity fused easily with modernization as progress of civilization. This does not mean that missionary politics of transformation can be collapsed under colonial government's modernization politics. As with all things historical, modernization and civilization are diverse and complex social practices. East Africa is a particularly good example.

The Swahili term *maendeleo* became the popular national motto, meaning progress, uplift and development, modernization, and – notably for government – order.[45] These debates had a longer history. The East African region has been a place where many different actors of

[41] John L. Comaroff et al., *Revelation and Revolution II*, 1997; Anna Laura Stoler et al., *Tensions of Empire*, 1997; Tony Ballantyne et al., eds., *Bodies in Contact: Rethinking Colonial Encounters in World History*, 2005; Siegfried Weichlein et al., eds., *Der schwarze Körper als Missionsgebiet*, 2016; Richard Hölzl, *Der Körper des Heiden als moderne Heterotopie*, in Historische Anthropologie, 2011.
[42] I learnt a lot on bodily practices in relation to historical change through the work of Rita Kesselring, *Bodies of Truth*, 2016, pp. 7-11.
[43] Rebecca Marsland, *Who are the Public?*, 2014; Osaak A. Olumwullah, *Dis-ease in the Colonial State*, 2002, p. 16; Stacey Langwick, *Bodies, Politics and African Healing*, 2011, p. 11; Julie Livingston, *Debility and the Moral Imagination*, 2005; Markku Hokkanen, *Moral Transgression*, in Asclepio. Revista de Historia de la Medicina y de la Ciencia, 2009; David Schoenbrun, *Conjuring*, in The American Historical Review, 2006.
[44] Kunibert Lussy et al., *Religiöse Anschauungen und Bräuche bei den Wapogoro*, in Anthropos, 1954; Lorne Larson, *Problems in the study of witchcraft eradiction movements in Southern Tanzania*, in Ufahamu, 1976; Maia Green, *Witchraft Suppression Practices*, in Comparative Studies in Society and History, 1997.
[45] Claire Mercer, *Discourse of Maendeleo*, in Development and change, 2002, p. 111; Maia Green, *Participatory Development*, in Critique of Anthropology, 2000; James R. Brennan, *Taifa*, 2012, pp. 146-148; Emma Hunter, *History of Maendeleo*, 2014; Robert M. Ahearne, *Development and Progress*, in African Studies Review, 2016.

modernization met and multiple forms of modernization thrived. Swahili culture and growing Muslim networks produced alternative forms of modernization in the late 19th and 20th centuries. In this context, religion – not exclusively Christianity – mattered in the process of civilization, and vice versa.[46] So, when Africans put progress to the test, they measured civilization not only in monetary terms, but also in currencies of social health and healing, and the stakes for medical work in the contest of spiritual worldviews rose considerably.[47]

As we are looking at mission health institutions as development, this dissertation argues that the establishment of mission medicine itself was co-produced by a wide range of actors within changing configurations of development in a transnational context, rather than a fixed import of institutions. Although (bio)medicine was practised by 'vibrant networks' across the globe, it was not made into coherent practice, but constituted as a matter of conflict and contestations, and remained a diverse and slippery concept.[48] Biomedicine and its institutions were slippery, and health itself a moving concept. Healing processes always remained unpredictable and needed a constant production of ontologies and explanations of modes of operations by the patient and society. While all kinds of health institutions tried to explain disease and healing and to fix knowledge that undergirded these explanations, the healing process remained a space of constant negotiation. Those settings were hybrid, ambivalent, transcultural contact zones, Third Space, that were co-produced by mission and that co-produced missionary healing.[49]

In Kiswahili, the sociohistorical concept of health is close to the idea of wellbeing, *uzima*.[50] Before disease comes into social existence as illness, a complex process of negotiation, naming, defining and explaining is necessary.[51] This is never a neutral process, as much as medicine tries to claim that it is. It is a process that is historically, culturally, and morally ordered. There were different ways to promote *uzima*, and there was both a 'deep ontological divide' as well as a'cross-germination' between these different epistemes: this gave Africa its plural medical landscape, but also formed biomedicine in particular ways.[52] As I argue later in

[46] James R. Brennan, *Taifa*, 2012, 146-148.
[47] Rebecca Marsland, *Who are the Public?*, 2014.
[48] Waltraud Ernst et al., *From History of Colonial Medicine to Plural Medicine in a Global Perspective*, in NTM Zeitschrift für Geschichte der Wissenschaften, Technik und Medizin, 2009; Mark Harrison, *From Western Medicine to Global Medicine - Introduction*, 2009; Patrick Harries et al., *Medizin und Magie*, 2012. On biomedicine see: Waltraud Ernst, *Plural Medicine*, 2002; Ilana Löwy, *Historiography of Biomedicine: "Bio", "Medicine", and In Between*, in Isis, 2011; Walter Bruchhausen, *Biomedizin*, in N.T.M., 2010. In these local contexts, a wide array of actors, which included modernizing healers and a good number of proto-professional actors amongst them, practiced forms of modernized medicine: Nancy Rose Hunt, *Colonial Lexicon*, 1999; Walima T. Kalusa, *Language, Medical Auxiliaries*, in Journal of Eastern African Studies, 2007; Susan Reynolds Whyte et al., *Social Lives of Medicines*, 2003; Megan Vaughan, *Healing and Curing*, in Social History of Medicine, 1994; Megan Vaughan, *Health and Hegemony*, 1994, p. 173.
[49] Homi K. Bhabha, *The location of culture*, (London [etc.]: Routledge, 1994). Richard Hölzl, "Soziale Mission [Editorial]" in *WerkstattGeschichte*, no. 57 (2011).
[50] Michael Singleton, *Du salut à la santé: demandes africaines et offres d'églises*, 1991, pp. 141-146.
[51] Marcel Dreier, *Disease at the Confluence of Knowledge*, 2019.
[52] Charles E. Rosenberg et al., *Framing Disease*, 1992, Introduction; Steven Feierman, *Culture, Technology and Poverty*, 2004, p. 8; Claire L. Wendland, *A Heart for the Work*, 2010, Introduction.

this introduction, an institution like a hospital offers handles to the historian to get a grip on these social practices and to discuss the making and working of development.

It is enlightening to look at the concept of 'modern medicine' as articulated in Tanzanian society, in order to better understand this diversity. The term *dawa,* which missionaries adopted from Swahili, already carries a composite history with it.[53] *Dawa ya kisasa*, the medicine of biomedical institutions, literally means 'contemporary or modern medicine'. It is used to differentiate 'modern' from 'traditional' medicine, but signifies more than just a time-related form of medicine. The term most used today for the traditional is *dawa ya kienyeji*, which means 'local' rather than 'old' medicine.[54] The way the terms *kisasa* and *kienyeji* are more than binary hints at the fact that medical epistemes are conceptualized not simply as elements of progress on a timeline extending from 'ignorance' to 'rational knowledge': the Kiswahili terms also make the presence of social networks and relationships and diverse sources and forms of power visible. There is a power that emanates from the connection to the local place, producing effects that are different from the medicine from foreign places – which, remember, is not explicitly called 'foreign'.[55] Being modern, Maia Green holds, "is also a status, articulated through participation in what are classified as Western, imported practices and styles."[56] A medical administrator in the early 1950s, therefore, complained that the "schoolboys become very 'medicine minded' and are [...] inculcated with the idea that the cure for each and every ill is a dose of medicine or (better still) an injection".[57]

The *dawa ya kisasa* of the mission was not 'purely' rational: in Switzerland, Capuchin medicine was notoriously non-secular. Capuchins were popular healers in Switzerland, and their cures, known as 'Capuchins' materia', were even used by Protestants.[58] Catholic religious practice itself offered many rituals for healing: in Ulanga there were numerous 'medicines of the church', like holy water, blessed oils, palm branches, etc. When the Sultan of Mahenge fell ill in the early 1930s, local Catholics prayed a *novena*, a ritualized nine-day series of prayers for his recovery. In Mchombe, the Capuchin missionary organized a *novena* to counter the threat of competition by a new government school in combination with the arrival of sleeping sickness in the area. During a typhus epidemic, the missionaries addressed their prayers specifically to the Bavarian Capuchin brother Konrad of Parzham, who had recently been blessed by the Pope.

[53] Amina Ameir Issa, *Stinkibar to Zanzibar*, 2009, p. 88. The Swiss nuns soon adopted titles like "*Bibi/Mama ya Dawa*": *Krankheit und Krankenpflege in unseren Missionen*, in Missionsbote der Schweizer Kapuziner in Afrika, 1924; Sr. M. Margrith Bösch, *Die Reise nach der neuen Missionstation Kipatimu*, in Providentia, 1930.
[54] Langwick and Bruchhausen have found very similar usage: Stacey Langwick, *Bodies, Politics and African Healing*, 2011, pp. 87-88, 263n263; Walter Bruchhausen, *Medizin zwischen den Welten*, 2006. Also Felicitas Becker, *Becoming Muslim*, 2008, pp. 106-107, 205; Rebecca Marsland, *Modern Traditional Healer*, in Journal of Southern African Studies, 2007, p. 754; Jamie Monson, *Tribal Past*, 2005, p. 111; Patrick Thomas Malloy, *Holding by the Sindano*, 2003, pp. 293-295.
[55] Maia Green, *Medicines and Embodiment*, in The Journal of the Royal Anthropological Institute, 1996, p. 189; Susan Reynolds Whyte et al., *Social Lives of Medicines*, 2003; Walter Bruchhausen, *Medizin zwischen den Welten*, 2006, pp. 145ff. See also A. G. O. Hodgson, *Some Notes on the Wahehe of Mahenge District, Tanganyika Territory*, in The Journal of the Royal Anthropological Institute of Great Britain and Ireland, 1926, pp. 56-57; James Giblin et al., *Introduction*, 2010, p. 25.
[56] Maia Green, *Participatory Development*, in Critique of Anthropology, 2000, p. 78.
[57] TNA 450/1508/8: *Annual Report Eastern Medical Region, 1951*.
[58] Peter Hersche, *Agrarische Religiosität*, 2013, pp. 148-155.

Another sister proudly reported how she had helped a woman to a surprising recovery by the application of holy water when all had seemed lost.[59]

This medicine was practised by healers without doctors' certificates, and so the medical marketplace was wide and blurred, with extensive ideas about what a healer or doctor, a *mganga*, was. When ethnographers in Ulanga inspected the medicinal bag of a healer called Tembatemba in the mid-1930s, they found that it contained:

> roots and herbs of all descriptions, rams' horns filled with evil-smelling concoctions, a few cents, a little tobacco, a double string of beads with a shell at either end which he uses for divining, a very soiled breviary which he picked up somewhere or other and to which he obviously attaches considerable value although he cannot read, and his photograph which he treasures as his mtima or life-giving spirit.[60]

In the process of the constitution of *dawa ya kisasa*, the dispensary or the hospital became a space of negotiated social change, re-inscribing the practices of development in the context of colonial and postcolonial forms of pastoral power. Demands on medical services were negotiated inside the institution itself or in the framework of the debate about the existence and character of the institution in wider society. By looking at Ulanga, we can discuss health and medicine as social fields of contestations about the value of different bodies of knowledge that organized concrete negotiations of ideas and practices of development.[61] So let me now turn to introducing and presenting the concrete material of this dissertation.

## Switzerland Entangled

The small town, Ifakara, in the Kilombero Valley in Southern Tanzania, lent its name to the Ifakara Health Institute, a globally connected and respected scientific institution that extended its reach to and beyond the major city of Tanzania, Dar es Salaam.[62] In Switzerland, Ifakara is quite a trademark, too. Hundreds of Swiss people have visited or even lived in Ifakara in the last 90 years, and it is not difficult to find a person with whom to share a story or two about Ifakara within the circle of Swiss scientists with an interest in Africa. Debates about experiences in Ifakara have even influenced development cooperation in Switzerland.[63] During the period of research for this thesis, Ifakara was visited by the the highest-ranking representative of the Swiss state, National Assembly President Maya Graf, by the Swiss Federal

[59] Maia Green, *Medicines and Embodiment*, in The Journal of the Royal Anthropological Institute, 1996, p. 492. P. Gustav Nigg, *Sultan Joachim ist tot!*, in Missionsbote der Schweizer Kapuziner in Afrika, 1933; Joseph Leon. Tschudi, *40 Jahre Mchombe*, in Missionsbote der Schweizer Kapuziner in Afrika, 1954; P. Fridolin Fischli, *Gruss aus Kwiro*, in Missionsbote der Schweizer Kapuziner in Afrika, 1932. The epidemic threatened the existence of the catholic boardings school: Sr. M. Nikolata, *Kwiro / Bei den Typhuskranken*, in Providentia, 1931; Sr. Floriana Jud, *Angstvolle Stunden*, in Missionsbote der Schweizer Kapuziner in Afrika, 1936.
[60] A. T. Culwick et al., *Ubena of the Rivers*, 1935, pp. 117-118.
[61] Patrick Harries et al., *Medizin und Magie*, 2012; Helen Tilley, *Global History, Vernacular Science*, in Isis, 2010.
[62] Lukas Meier has researched and written a skillful history which describes and analyses this institution from a global science history perspective. I owe many of my insights to our joint time as researchers of history of science, medicine and global connections, both in Ifakara and Basel. Lukas Meier, *Swiss Science*, 2014.
[63] Lukas Meier, *Macht des Empfängers*, 2014.

Councillor Micheline Calmy-Rey, as well as by Daniel Vasella, leader of the Basel-based pharmaceutical giant Novartis and the highest-earning CEO in the history of Switzerland. Ifakara earned itself a chapter in a lucid parody on Swiss 'know-how' in the tropics, and its name was displayed on the title page of a crime story that starts and ends in Zurich and on the label of a small Swiss clothing company producing 'social and ethical fashion'. Journalist Jürg Bürgi described Ifakara as a *Kraftort*, an 'energy spot' for sustainable development.[64]

The roots of these links and the importance of Ifakara as a place of development lie in the historical entanglement of Ifakara with the Swiss Capuchin Mission in East Africa. With the Swiss female congregation of the Sisters of Baldegg, based mostly in rural Lucerne, the Capuchins headed a large investment of (wo)manpower and capital in the southern parts of Tanzania over many decades. That the Catholic mission contributed to (medical) development in the era has been described in other dissertations. Edgar Widmer wrote a thesis in 1963, well-informed by missionary sources, as did Eduard Desax in 1975.[65] Notably, Desax was guided towards his topic by Walbert Bühlmann, a Capuchin missionary, modernizer of mission theory, propagandist, and leading ideologist of Catholic development aid, who had spent most of his formative African years in Ifakara.[66] Both Widmer and Desax had access to written sources and oral accounts of people who are no longer alive, and both made bold claims about the contribution of the Swiss Capuchin Mission to the social development and welfare of people living in Ifakara and the larger region. They argued that the mission invested in the 'raising of the African' by means of a range of institutions of trade, education, social welfare, and medicine, all of which were seen as preparing the soil for Christianity.[67]

The idea that missionaries produced the foundations of welfare and development is widespread in Ulanga. Callistus Mdai, a prominent and longstanding church figure in the area, stated in a volume celebrating the 75th anniversary of the Swiss Capuchins' presence in East Africa:

> As a child, I experienced the mission as the main resource for the Mahenge people [...] for education, health services, work, food (in times of scarcity), to mail letters, to open a savings account etc. Later, I came to understand the Swiss missionaries provided all these services as

[64] http://www.swisstph.ch/de/news/news/highest-swiss-politician-visits-swiss-tph-projects-in-tanzania.html. DEZA, "[Press-Release]: Bundesrätin Calmy-Rey in Tansania, 12.10.2010 ". Max Fischer, *Daniel Vasella: «Ein bisschen Menschenwürde geben»*, in Schweizer Illustrierte, 2009; Isolde Schaad, *Knowhow am Kilimandscharo*, 1984; Adrian Zschokke, *Ifakara*, 2000; Jürg Bürgi, "Ifakara - ein Kraftort nachhaltiger Entwicklung," http://www.juerg-buergi.ch/Archiv/EntwicklungspolitikA/EntwicklungspolitikA.html; Jürg Bürgi et al., *Mehr geben, weniger nehmen*, 2004; Cécile Koechlin et al., *Der Buschdoktor von Ifakara*, 1978.

[65] Eduard Desax, *Entwicklungshilfe*, 1975; Edgar Widmer, *Geschichte der schweizerischen ärztlichen Mission in Afrika*, 1963; PA Widmer Edgar Widmer, *Unterwegs für Entwicklung. Erinnerungen anhand von Fotografien*.

[66] Walbert Bühlmann, *Überraschungen meines Lebens*, 1994; Urs Altermatt et al., *Missionswesen im Wandel*, 1988, p. 35. Bühlmann is also heavily referenced in another history of the mission in Tanzania laying much weight on the material contribution of the mission towards development: Siegfried Hertlein, *Wege christlicher Verkündigung*, 1983, e.g. p. 37.

[67] Eduard Desax, *Entwicklungshilfe*, 1975, pp. 59-60. The first study in this argumentative tradition in relation to Ulanga was Franz Szczypior, *sozialwirtschaftliche Arbeit*, 1923.

> a matter of principle, resolve and commitment to work for the salvation and general upliftment of the whole person.[68]

Referring to a history that has not yet ended, the Mother General of the Diocesan Congregation of the Franciscan Sisters of Charity of St. Francis argued in 1997 that it tied white sisters and African Christians in "a mother-child relationship until death".[69] I have taken these claims about the *longue durée* history of missionary development work and the continued need for support as a major baseline for this dissertation.

Historians have pointed to the invention of a narrative about the tradition of missionary development.[70] Matzinger's foundational study on Swiss development cooperation briefly stated that the missions only placed their activities in the framework of development aid once it had entered Swiss public discourse.[71] Such a view risks underestimating the way in which development had indeed been ordered as a discourse and a field of practice in the regions where the missions were active, long before public discourse in Switzerland about development aid arose.[72] Most recently, Lukas Zürcher has shown this longer trajectory of Swiss engagement in Rwanda.[73] He is one of a number of Swiss historians who have invested considerable effort in writing a new history of Switzerland based on the idea of the country's global entanglements with other regions in the era of imperialism and colonialism.[74]

The recipient countries were often more important to the idea Switzerland developed about itself than Switzerland actually was for the development of these countries.[75] For example, from the 1920s, life in villages in Ulanga was intertwined with life in villages in Switzerland, where friends and families of missionaries invested in the mission, both financially and emotionally. In return, they received stories and images of rural life in Africa that helped them to find their place in the world.[76] Swiss Catholic organizational life was rich and filled with images from the mission field. The historical master narrative of the conservative modernity of Catholic

[68] Callistus Mdai, *My Experience with the Swiss Missionaries*, 1997, p. 32. Also in the very helpful interviews he gave me: *Interviews with Fr. Callistus Mdai, Kwiro, 16.02.2009 and 19.05.2010*.
[69] Joyce Seki, *Impressions from the Point of View of our Congregation Regarding Missionary Endeavour*, 1997, p. 107. The congregation had been founded by the Baldegg Sisters and the Swiss Archbishop Edgar Maranta in the early 1950s: Sr. Grace Shembetu, *Maranta*, 2000.
[70] In line with Zürcher, I suggest keeping the historical term 'development aid' in our analytical vocabularies: Lukas Zürcher, *Schweiz in Ruanda*, 2014, chapter 1 note 15.
[71] Albert Matzinger, *Anfänge*, 1991, pp. 160, 287n167; Urs Altermatt et al., *Missionswesen im Wandel*, 1988, p. 30.
[72] Swiss (Technical) Development Cooperation only started in 1960 at a time when church-based and some private organizations already ventured into development aid, often based on institutional networks and knowledge of missions. René Holenstein, *Was kümmert uns die Dritte Welt*, 1998.
[73] Lukas Zürcher, *Schweiz in Ruanda*, 2014; Albert Wirz, *Abolitionisten als Wegbereiter des Kolonialismus*, 1986, the quotes from pp. 24, 26; Monica Kalt, *Tiersmondismus in der Schweiz*, 2010, pp. 195, 199-203. The notion of 'development *avant la lettre*' also in Siegfried Weichlein et al., eds., *Der schwarze Körper als Missionsgebiet*, 2016, p. 16.
[74] A good introduction is Patricia Purtschert et al., *Bestandesaufnahme*, 2012, in particular pp. 30-31, 33. The term 'Entangled Switzerland' is programmatic in the same volume: Shalini Randeria, *Verflochtene Schweiz*, 2012. See also Patrick Minder, *Suisse Coloniale*, 2011; Konrad J. Kuhn et al., *Handlungsfeld Entwicklung*, 2014, p. 10; An Lac Truong Dinh, *Kühe, Fachkräfte und Kapital*, 2016.
[75] Sara Elmer, *Postkoloniale Erschliessung ferner Länder*, 2012, p. 245. For the wider implications of entanglements with Africa on Swiss society, see Patrick Harries, *Butterflies and Barbarians*, 2007, p. 4.
[76] Al Imfeld, *Auf den Strassen zum Himmel*, 2013; Marita Haller-Dirr, *Du schwarz, ich weiss*, 2012.

Swiss society does not, however, venture into global history.[77] Widmer and Altermatt stated in the late 1980s that new dynamics around the idea of mission were based on a 'realistic concept of mission' and popular organizations helped to sustain traditional Catholic organizations for another decade.[78] The contents of this realistic concept of mission in terms of practices and knowledge beyond Switzerland still remain vague. Mission studies scholars understood the international dimension, but then historians of Catholic missions are rare in Switzerland.[79] Clearly, though, by the early 1980s, the context at the St. Francis Hospital had changed, and secular concepts of medical work had taken over.[80]

The study of Swiss engagement in the development of health services in Tanzania contributes to "reframing the Swiss past in a transnational perspective".[81] In particular, it adds to a Swiss history that has lost the innocence, naiveté and amnesia – to use terms from Purtschert et al. – of the days when Switzerland was represented as a self-dependent and inward-looking island. A generation of scholars, inspired not least by Patrick Harries, depicts Switzerland's past as that of a country without formal colonies, but still with a colonial past. A colonial past that is complex, complicit, exoticising, and intimate, in which Swiss actors gatekept in an imperial context and drew profits from their entanglements with colonialism, both for themselves and for their friends with whom they entered into colonial figurations. At the same time, my own 'study of colonial margins' – another term by Purtschert et al – contributes, I hope, not only to a postcolonial reading of Swiss history, but also to the history of Tanzania in the age of colonialism. It shows that it is imperative to look beyond the colonial powers in order to understand how Tanzania and Tanzanians connected to the world in the 20th century.

## Ulanga Global

The Catholic mission of the Swiss entered a dynamic area which saw substantial changes in the 19th and 20th centuries.[82] As a designation of this area, the term Ulanga will be used

[77] Urs Altermatt, *Katholizismus und Moderne*, 1989 [1991], with short sections on external mission pp. 170-171, 240; Peter Hersche, *Agrarische Religiosität*, 2013; Andreas Henkelmann, *Caritasgeschichte*, 2008; Esther Vorburger-Bossart, *Bedürfnis der Zeit*, 2008, pp. 365-366.
[78] Urs Altermatt et al., *Missionswesen im Wandel*, 1988; René Holenstein, *Was kümmert uns die Dritte Welt*, 1998, pp. 127-141.
[79] Marita Haller has contributed to this historiography for many years: Marita Haller-Dirr, *Fragen an die Geschichte. A History in the Making*, 1997; Johannes Beckmann, *Die katholischen Schweizermissionen in Vergangenheit und Gegenwart*, in Studia Missionalia, 1956; Walbert Bühlmann, *Afrika*, 1963.
[80] A second volume to this dissertation remains yet to be written: apart from oral history, which should be completed soon, there is good archival material available in Switzerland (BAR and ASML) in which the influence of development experts' concepts on missionary medical institutions can be seen more clearly.
[81] Shalini Randeria, *Verflochtene Schweiz*, 2012.
[82] Jamie Monson, *Memory, Migration and the Authority of History*, in The Journal of African History, 2000, p. 361; Lorne Larson, *History of Mahenge*, 1976. Ethnographic work on the area up to the 1950s has been discussed by A. Brantschen, *Die ethnographische Literatur über den Ulanga-Distrikt*, in Acta Tropica, 1953; Sidonius Schoenaker, *Hintergründe*, 1965.

throughout this dissertation. I use it deliberately, imprecise as it is, because that accords with its history of shifting boundaries of settlement and political organization.[83]

Ulanga is a tropical area with a huge variety of ecosystems: flood-plain, steep forested mountain slopes and *miombo* bushland. Settlements tried to adapt to the opportunities and limitations for agricultural production.[84] Higher-yielding grains like rice and maize came to the Kilombero valley in the mid-19th century, and at the turn of the 20th century, Ulanga was a prime producer of natural rubber, honey, and ivory. By that time, southern Tanzania had become a rather unstable region, where conflict over wealth and access to trade led to violence, accelerated social change and substantial adoption of Islam.[85] Where there had once been traditions of chieftainship, these had been weakened for a long time, and by the end of the 19th century, colonial pressure and administration had stirred up new political systems and settlement patterns.[86] In the wake of the suppression of Maji Maji and with the cutting of trade routes to the south in the course of the establishment of the immense Selous Game Reserve, many parts of Ulanga, in particular the areas south of Mahenge, underwent a process that Maia Green called 'establishing marginality'. Other places benefited in the course of the 20th century from the arrival of new Muslim traders, from new roads, and eventually in the 1970s from the Tazara railway line.

Ifakara was one of these places and it became the centre of the Kilombero valley, which became an important area of agricultural production for the national market, primarily for rice and sugar.[87] The small township of Ifakara grew considerably in the 20th century. At the turn of the 21st century, Ifakara and its environs had over 80,000 inhabitants. In the late 1990s, some 95 per cent of the population depended on agriculture and an astonishing 7 per cent gave the existence of medical services as the reason for moving to this area, that not long ago had been reputed to be highly insalubrious.[88] In 1978, there were four hospitals with a total of 651 beds in the two districts of Kilombero and Mahenge. More than half of these beds (354), were in the Designated District Hospital in Ifakara. This Catholic institution employed more than 100 health professionals (apart from cooks, drivers etc).[89] In addition, the Catholic church kept just under

[83] In the early 20th century, what is today called the Kilombero river valley was considered the Ulanga river valley. A. T. Culwick et al., *Ubena of the Rivers*, 1935, see map inbetween pp. 28 and 29. Under German and British colonial administration the District was first called Mahenge and Ulanga from around October 1935. In 1974 it was split into Ulanga and Kilombero Districts. The Capuchin Mission did not have a clear name for the area either, which was always part of a larger geography of their mission work stretching to Dar es Salaam until, in 1964, the area became the Catholic Diocese of Mahenge. Joachim Pfeil, *Die Erforschung des Ulanga-Gebietes*, in Petermann's geographische Mittheilungen, 1886; Joseph Thomson, *Expeditionen*, 1882, p. 145, on his self-perception as a model of civilised hygiene pp. 141-142, 147.

[84] R. Jätzold et al., *Kilombero Valley*, 1968; Rudolf Peter Mayombo, *Economic structural changes and population migration in Kilombero Valley*, 1990; Jamie Monson, *Agricultural Transformation*, 1991.

[85] John Iliffe, *Modern History of Tanganyika*, 1979; Thaddeus Raymond Sunseri, *Vilimani*, 2002; James L. Giblin et al., *Maji Maji*, 2010; Felicitas Becker, *Becoming Muslim*, 2008.

[86] Jamie Monson, *Relocating Maji Maji*, in The Journal of African History, 1998; Lorne Larson, *History of Mahenge*, 1976.

[87] Jamie Monson, *Africa's Freedom Railway*, 2009.

[88] Anthony Alifa Chamwali, *Survival and Accumulation Strategies*, 2000, pp. 13, 16. On Ifakara, see also Mkeli Pio Senga Mbosa, *Colonial production and underdevelopment in Ulanga district, 1894-1950* 1989.

[89] Tanzania Ministry of Health, *Inventory of Health Facilities 1978: 11 Morogoro Region*, 1979. Lutherans ran another mission hospital, the Lugala hospital in Malinyi; the Kilombero sugar company operated a hospital, often with no doctor and

200 beds in dispensaries (where there was no academically trained doctor in charge) and, again in Ifakara, a permanent institution for 160 people suffering from leprosy. Thus, at the start of the 21st century, the Catholic church catered for roughly two-thirds of total inpatient medical services in this part of Tanzania. From 2010, when I completed field research in Ulanga, the St. Francis Hospital became the medical training faculty for the Catholic University of Mwanza and a refurbishment project for the hospital was initiated with major funding from the Swiss Agency for Development and Cooperation.[90]

## Rural Location and History

Rural Tanzania is the geographical and historical space in which these health institutions came to life. The rural is, however, not an ahistorical fact in itself, but was created as a space with discursive characteristics through the very processes we are looking at: issues of governance, economy, and even the very history of the health services have contributed to the production of rurality in Ulanga.[91] This dissertation contributes to understanding the rural as something that is much more than just a periphery, but an arena of the global in its own right.

The rural had constituted a specific field for government healthcare policies and organization from early on, not least in Tanganyika, that was seen as essentially rural by the British as much as by the postcolonial state ideology of *ujamaa*.[92] In the 1950s, the rural came into the focus of welfare organizations in Tanganyika. 'Community Development' established development of the 1940s and 1950s as a state-oriented (and -moderated) hegemonic project.[93] In a time of political strife and unrest, when 'nationalists' sought rights for the individual, colonial governments re-imagined the rural as a place of social harmony, and the invention of 'community' replaced the invented 'tribe.' In medical policy words, this meant that the medical administration had to "convince the population groups now being served that they have a community responsibility themselves to reduce their local burden of sickness."[94]

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in Mahenge; the former Catholic mission hospital had been taken over by government in the late 1940s. For a historically infused argument about the geographical situation of health units in Tanzania see Ian D. Thomas et al., *Health Facilities and Population in Tanzania*, 1973.

[90] https://www.eda.admin.ch/dam/countries/countries-content/tanzania/en/601.0-00_Factsheet_SDC_SFRH_EN.pdf

[91] Sara Berry, *No Condition Is Permanent*, 1993.

[92] Olumwullah has looked at the construction of the problem of rural health: Osaak A. Olumwullah, *Dis-ease in the Colonial State*, 2002, pp. 205-216. Many historians, often those with an interest in mission medicine, have looked at rural health, but not with an interest in the constitution of a specific field in medical expertise, although it exists: Sana Loue et al., *Handbook of rural health*, 2001. On Tanzania specifically: Gerardus Maria van Etten, *Rural Health Development in Tanzania*, 1976. Ujamaa ideologies notwithstanding, the Tanzanian reality was one of 'urban bias' with a much more extractive accumulation in rural than in urban areas: James R. Brennan, *Taifa*, 2012, pp. 167-173.

[93] Hubertus Büschel, *Hilfe zur Selbsthilfe*, 2014, pp. 163-165; Jocelyn Alexander, *Unsettled Land*, 2006, pp. 65-67.

[94] John Iliffe, *African Poor*, 1987, p. 204; Michael Jennings, *Building Better People*, in Journal of Eastern African Studies, 2009; TNA 692: P.A.T Sneath, *Letter to Chairman Medical Missionary Commitee, M.J. Gibbons. DSM 25.08.1947*. Institutions advanced the constitution of communities in a social and scientific process that grew from a medical 'fact' or a common suffering: Eric Silla, *People Are Not The Same*, 1998; Susan Reynolds Whyte, *Health Identities and Subjectivities*, in Medical Anthropology Quarterly, 2009; Richard Rottenburg, *Social and public experiments*, in Postcolonial Studies, 2009.

The practices in rural areas and the experiences influenced redesigns of development in the centres and metropole. As hospitals spread across the globe, even to areas defined as entirely rural, they were part of the institutionalization of elements of a 'world culture', whereby "people around the globe increasingly organize their common life on the basis of shared knowledge and principles."[95] But this was not a culture that was simply carried into the periphery. The rural world and the experience in the field were rich sources from which practical lessons and information on 'how to develop' were gained.[96]

## History of Mission Medicine Institutions

The method of my choice to reconstruct historical concepts, negotiations of disease and the production of (ill)health in a rural society is to look at practices, material objects, and how they coagulated in institutions that I can place under our gaze. In this dissertation, concrete historical articulations of institutions of modern medicine, epitomized by the hospital, but including rural dispensaries, maternal health clinics, and public demonstrations, will be analysed.[97] These are my entry points as a historian, to elicit who intervened, for which reasons, through which relationships, and to what effect.[98]

A hospital like the St. Francis Hospital in Ifakara was more than just an organization. It was a social structure that was made to fulfil certain expectations regarding its aims and manner of operation, that were produced, not least, through comparison with the larger institutional concept of 'the hospital.' But the negotiations about the role of this institution were never limited to the hospital site: at the very beginning of research for this study, I participated in a workshop where we found that the "hospital is [was] a microcosm of the world outside the hospital walls".[99] Such modernizing institutions like hospitals were explicitly posited as central pillars of development activities and were meant to be catalysts for interventions and transfers. They served as a place of social order and change at the same time.

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[95] Frank J. Lechner et al., *World Culture*, 2006, pp. 2, 4. Roland Robertson, *Glocalization*, 1995; James Ferguson, *Global Shadows*, 2006. Hospitals were seats of diverse transnational actors drawing on the symbolic capital of development, see for an interesting example a Muslim hospital established in 2003 in Senegal: Ellen E. Foley et al., *Diaspora, faith, and science: building a mouride hospital in Senegal*, in African Affairs, 2011.

[96] Rural hospitals, like Saint Francis in Ifakara became transformational experiences for doctors in the South. See the reports of doctors from Ifakara in the Archive of Solidarmed in Luzern (ASML). Maurice H. King, *Medical Care in Developing Countries*, 1966. More broadly on rural development, the work of Robert Chambers, for example Robert Chambers, *Managing Rural Development: ideas and experiences from East Africa*, 1974.

[97] Mark Harrison, *From Western Medicine to Global Medicine - Introduction*, 2009. Anne Digby et al., *At The Heart Of Healing*, 2008. Pascal Schmid, *Medicine, Faith and Politics*, 2018; Hines Mabika, *Swiss medical practice in South Africa*, in Schweizerische Zeitschrift für Geschichte, 2017; Vanessa Noble et al., *People's hospital*, 2017. Tizian Zumthurn on Lambarene (forthcoming). For a broader history of hospitals: Guenter B. Risse, *Mending bodies, saving souls: a history of hospitals*, (New York: Oxford University Press, 1999).

[98] see footnote 19.

[99] The workshop "The history of the hospital as a biomedical and social institution in Africa, with special reference to the Swiss mission and South African experiences" was funded by the Swiss National Science Foundation and held in Basel in January 2008. The quote is from the final report submitted to the SNF 27.7.2008. For a brief introduction into the relationship of disease, society and health see Howard Phillips, *Plague, Pox and Pandemics*, 2012.

Institutions structure and enforce behaviour and reflect distributions of power in coagulated forms. They also contain conflict. Institutions regulate and stabilize social behaviour as a body of values, regulations and conventions, but their way of organizing does not remain unchallenged, even from within. As a consequence, institutions structure their own change in specific ways.[100] There are often divergent forces representing very different interests within the institution, and even where health institutions were a coagulation of empire, benevolent or capitalist, they contained elements of slippage.

In the case of St. Francis Hospital, the hospital could serve – in parallel – the purposes of development, clinical medicine, networking hub, political legitimation, regional identification, proselytizing, tourism, salvation, professional careers, drugs source for illicit trade, marketplace for agricultural produce, etc. Looking at the hospital as an institution beyond its built walls, this dissertation understands development as a factor contributing to the remaking of power and contributing to broader social change beyond the direct aims of its interventions.

This thesis thus draws from historical institutionalism's interest in understanding "the intrinsic ambiguity of institutions [...and] their underpinnings in norms that are always subject to interpretation and frequently to reinterpretation." These institutional slippages and even 'institutional breaks' are what interest the historian.[101] The slippery character of institutions is of particular importance in the transnational and transcultural context of development. That institutions (and history) matter for development has gained recognition in political sciences and economy in the last decade.[102] In development practice, institutions are at the centre of a technical process of planned transfers, but colonial and postcolonial health institutions did not become exact replicas of metropolitan institutional templates. Instead, they had their own specific characteristics, aspirations and trajectories.

Certainly, missionary theory believed that charitable institutions could regulate and change behaviour in order to bring progress. And thus, missions created hospitals which not only aimed at saving lives, but also at transforming them. But although at moments missions were convinced that dispensaries and hospitals were good institutions through which to enact interventions and a fast track to the soul of the 'native', in practice they also had to learn to negotiate and adapt these institutions, not only to the ideas of the users of services, but also to government policies and the often fragile technical and financial base of the mission.[103] In fact, even where such institutions developed as a part of interventionist colonial policies, they did not

[100] Margaret Levi, *A Logic of Institutional Change*, 1990; Paul Pierson, *Increasing Returns, Path Dependence*, in American Political Science Review, 2000. New historical institutionalism looks at the way in which institutions organize power, and how they stabilize and structure historical process: Kathleen Thelen, *Historical Institutionalism in comparative Politics*, in Annual Review of Political Science, 1999; James Mahoney et al., eds., *Explaining Institutional Change*, 2010; Peter A. Hall et al., *Three New Institutionalisms*, in Political Studies, 1996.

[101] Peter A. Hall et al., *Three New Institutionalisms*, in Political Studies, 1996. On institutional breaks: Helge Wendt, *Mission transnational*, in Schweizerische Zeitschrift für Religions- und Kulturgeschichte, 2011.

[102] Michael Woolcock et al., *How and Why Does History Matter for Development Policy?*, in The Journal of Development Studies, 2011.

[103] Markku Hokkanen, *Quests for Health*, in Journal of Southern African Studies, 2007.

function as a one-way tool of intervention, but – as translocal nodes – they co-produced development on the 'periphery'.[104]

That is why, in this dissertation, as much as it puts institutions at its core, I do not regard mission medical institutions as a fixed category conclusively defined in the missiological textbook, but rather as a Third Space, in which a localized practice coagulated, a practice grown from transnational entanglements, that incorporated and expelled knowledge and people and that shaped and expressed changing configurations of development.

Not least, institutions have a tendency to produce sources that document their own lives.

## Archives, Sources

The St. Francis Hospital in Ifakara did not keep any of its documentation from the period before the mid-1990s – apart from patient files that are still in use. Later administrative documents are still at the hospital's administrative offices, but do not document the period under discussion here, and the hospital library is of very limited use to the historian. Whatever had once been there did not survive extensive clean-up activity in 2007.[105] This narrative was therefore written without a hospital archive. The absence of an established and readily available hospital archive sent me on a paper trail to many other archives.

Most of the data stems from a range of archives and journals produced by the mission, i.e. the Swiss Province of the Capuchin Order's Mission to East Africa and the Sisters of the Divine Providence, the Baldegg Sisters. The Catholic mission archives used were not studied in their full extent; rather, material related to medicine and welfare was concentrated on. Mission journals contain a lot of stories, which I opted to use extensively so that the information from these sources becomes more usable to historians without easy access to the German language (and script) orcopies of journals.

With their background of strong hierarchy and tradition of secretive decision-making, the Catholic mission archives I worked with for this thesis rarely represent conflicting perspectives in a pronounced way. Some hypothetically interesting bodies of sources, for example those of the administrative offices of the Archdiocese of Dar es Salaam, never found their way into accessible archives. From the mid-1960s, the hospital fell under the authority of the Diocese of Mahenge, but the archive hardly documents medical activities.

The former mission organizations were open to sharing their archival holdings. Much of the value of the archive of the Capuchins in Dar es Salaam is due to the substantial archivist input the collection received at the turn of the 20th century from the historian Marita Haller with

[104] Ulrike Freitag et al., *Translocality*; Sebastian Conrad, *Rethinking German Colonialism*, in The Journal of Imperial and Commonwealth History, 2013; Patrick O'Brien, *Historiographical Traditions*, in Journal of Global History, 2006. Every medicine has its map, see Steven Feierman et al., *Social Basis - Introduction*, 1992, p. 2. See also Arjun Appadurai, *Production of Locality*, 1996.

[105] Personal information, Christine 'Mama' Schennach, Ifakara, 13.02.2009.

the support of the Capuchin Province. The structure of this archive shows clearly that the dispensary and hospital in Ifakara were not autonomous mission stations producing a defined and comparably comprehensive body of archived documents. In the case of the dispensary, this means that hardly any documentation on its daily work has survived. The depiction of the hospital in the archive is erratic, too. This reflects the fact that, up to the end of the 1960s, the doctors and sisters at the hospital seem not to have been required to legitimize their practice to the mission in a bureaucratic manner, while there was not strong interference from church bodies in the running of the hospital. On the other hand, the Swiss Capuchins in Tanzania were, until the mid-1970s, central figures in the hospital's administrative and financial support structure. This support is mirrored in the archive. Many outside contacts of the hospital were channelled through the mission's organizational framework: missionary trucks transported medical goods, doctors and building materials, missionary accounts transferred subventions and donations and managed social insurance policies for expatriate health workers.

The archive of the Swiss Capuchin Province in Lucerne (PAL) is not primarily an archive of the mission, but of the Capuchin Order. The same is true for the archive of the Baldegg. The mother house of the Baldegg sisters is the most important archive documenting the work of this female congregation and of the individual nuns and nurses in Tanzania. The archive houses the chronicles of many stations that were brought back by the sisters at the time of handing over to local partner congregations. All in all, however, Catholic nuns were exceptionally diffident about writing. Their approach to documentation was pragmatic and even abridged. The stations' chronicles are hardly ever more than lists of arrivals and departures, often not kept over long periods. This is foremost an orally producing culture in terms of intellect which sported a hands-on work ethic.

Documents on conceptual and strategic activities are sparsely documented in the Capuchin's Provincial Archive in Dar es Salaam (PADSM). These issues are better represented in the state archives of Tanzania and Switzerland. In the Tanzanian National Archives (TNA), documentation from about 1960 is largely absent or could not be retrieved. Where the TNA stops, the Bundesarchiv in Bern (BAR) begins: starting more or less in the early 1960s, it holds the collection of the Swiss Consulate and Embassy in Tanzania and of the Swiss Development Cooperation agencies.

Life inside the hospital is best documented in the archive of Solidarmed in Luzern (ASML), an up-to-date NGO that grew from the former Catholic Swiss Association for Mission Medicine.[106] Additionally, the Swiss Tropical and Public Health Institute collected a range of documents related to the history of Catholic medical institutions in Ulanga. It was an advantage,

[106] This 'archive' has in the meantime been transferred to a new location. All signatures I use in this thesis are probably obsolete. They give the placement of the files and folders in the former Archive's room and I have documented the rows in which the folders were with photographs. I had not, however, entered the signatures on the files themselves.

therefore, to have access to private collections as well as other missionary archives. Between 2008 and 2010, I also spent a couple of months every year in Ifakara to conduct, alongside local mediators and translators, a series of semi-structured interviews and focus group discussions with staff and former staff of the hospital and with people in Ifakara and Ruaha.

## Chapters

The first group of chapters analyses the period from the 1920s to the end of the 1940s. Chapter 1 shows how Swiss missionaries came to practise mission medicine in Tanganyika and the bodies of knowledge from which these almost entirely inexperienced Swiss Catholics drew when they touched ground in their new mission field. The Capuchin medical enterprise was largely preoccupied with the creation of communities and was steeped in the Catholic tradition of charity – *caritas*. However, these practices of *caritas* took place in a colonial environment at the periphery of an empire. Chapters 2, 3 and 4 discuss state medicine as a factor of colonial governance and the modernization of rural life in interwar Tanganyika from different perspectives. Chapter 2 looks at the making of a colonial health system and focuses especially on the political side of this early phase in the process of institutionalization of the 'health system'.

Along with the establishment of dispensaries, the state also supported the creation of a proto-professional class of health workers. These health workers, known as ‘dressers’, and their medical practices, are examined in chapter 3. Both chapters show how fragile the rural health system was at the time of its establishment as a state domain. Based on depictions of the conditions of life in the district, and on development projects initiated by the District Officer A.T. Culwick, chapter 4 shows how rural medicine in Ulanga was jump-started and how the depth of intervention increased with the arrival of science and development in the early 1940s. 'Rural' people now came under the gaze of science, and were forcefully resettled in the name of their own health.

Chapter 5 continues to show how the mission integrated into these historical developments by inserting its activities into agendas of social engineering that were informed by scientific knowledge and imperial discourses about development. In the example discussed – the modernization of birthing practices in the St. Anna Clinic in Ifakara – it becomes obvious how these large processes were touching local life in intimate ways. This chapter is a cornerstone of the story, not only because it leads the narrative back to the history of mission medical practice: it also discusses how women became a major focus of health discourses and how this process – which was a global preoccupation – was linked to a specific health institution in Ifakara, the St. Anna Clinic for mothers. This chapter discusses how science, maternalism, Catholic missionary ideals about reproduction, and the compassionate dedication of a mission nurse to the cause of safe motherhood and children's health coagulated into a health institution, and also how an

intensive process of negotiation unravelled around the modernization of birthing. As the woman behind the institution, Sr. Arnolda, became the 'mother of Ulanga', her dispensary and maternity clinic became the embodiment of the *raison d'être* of health and care institutions in the area of Ifakara and the hotspot of expectations about modernity. Importantly, it also expanded the notion of what a hospital was and what services it should deliver. At first the mission had not really pushed these secular and scientific developments, but it later came to support the welfarist politics entailed in interventionist colonialism.

Chapter 6 ends the first part of the narrative. It introduces us to medicine directed and practised by doctors as we explore processes of medicalization and secularization in the mid-1930s to the mid-1940s. These processes did not lead to a polished institutionalization of biomedicine, however. On the contrary, the chapter tells the story of institutional failures in leprosy control and with the first Mission Hospital in Mahenge. Shaken by internal conflict, the mission had to give up its investment in the hospital sector only four years later. This was the anticlimax of the mission's medical work. The fact that hospital medical activity ended in such crisis stands in stark contrast to the substantial investment that the mission eventually undertook almost a decade later, when it started to build a large, eventually 370-bed hospital in Ifakara, the St. Francis Mission Hospital.

The St. Francis Hospital is at the centre of the second series of chapters, which are concerned with the era of late colonialism and decolonization. Chapter 7 discusses this era, marked by the end of empire and the dawn of a world of new nations. Here, analysis is made of how the mission positioned itself in this situation of changes and continuities in political and social terms. The Capuchin Swiss Bishop Edgar Maranta was an important voice in answering the question about the future role of the church in an African nation, and how this made investment in the hospital sector attractive.

Chapter 8 relates the medical practice at the St. Francis Hospital in the 1950s and 1960s. Dedicated to 'modern medicine', the hospital was a beacon of development in the era of modernization theory and at the same time a late colonial medical institution. In essence, the chapter is interested in understanding how the practice of medicine in the hospital influenced the expectations of hospital medicine in Ulanga. It was the period that laid the foundation for St. Francis Hospital's legacy as a provider of better than average medical and surgical care.

Chapter 9 extends this local hospital history and looks at the role of Ifakara in the production of development cooperation between Switzerland and Tanzania in the 1960s. One of the important aspects of this period was the proliferation of actors in Ifakara who joined development activities. Around the mission and the hospital, a cluster of institutions developed, which were driven by private actors rather than by states. As an institution, St. Francis Mission Hospital now became a central node in a comparatively dense network of interests in health and development in Tanzania. The hospital also entered a process of localization and

internationalization at the same time. As the mission turned into a locally-based church and ownership of the hospital went to the new, but poor, diocese of Mahenge, the standards for medicine became linked to expert-driven internationally acclaimed policies and best practices. As the nation-state – weak in resources – framed the entitlements of humans, i.e. citizens, the hospital was measured against new benchmarks of international debates. As Tanzania invested in a distinctly rural and social development-oriented health system in the early 1970s, the tensions between the promises of late colonial modernization and the capacities of the Tanzanian state to procure health care services for all its citizens challenged the hospital to embark on a path of what was termed 'Africanization'. This path was marked in 1976 by the designation of the hospital as a district hospital, and therefore as a functional element of the national health care system. The concluding chapter discusses issues related to the practice of rural health and Africanization. It aims to sharpen understanding of the long-term processes that prepared the hospital to face the challenges that would arrive in the 1980s and 1990s, when the economic crisis in Tanzania and structural adjustments thinned out the resources of the Tanzanian government to provide health care services. This period, in which the institutional aspects of the St. Francis Hospital in Ifakara became most pronounced, will, however, not be elaborated on in this thesis. That calls for a sequel.

# Chapter 1 Launching into Missionary Medicine in Ulanga

The events charted in this chapter begin to unwind at a moment when "interventionist colonialism" was taking off.[1] German colonialism across Tanganyika had tried to develop an economy based on agriculture and forestry.[2] In the south- central parts of Tanganyika, German colonialism had caused more bloodshed than had occurred in other parts of Eastern Africa and had also impacted in a destructive way on economic life and on individual livelihoods. German colonialism disrupted existing social networks and had turned the Southern parts of Tanganyika into a periphery.[3] When the British took over the management of the territory of Tanganyika Territory under a mandate from the League of Nations, their allocated task was to bring progress to Ulanga.[4] Under both colonial regimes, the "civilizing mission" might have been an ideal; the reality however was the development of underdevelopment.[5]

However, the British administration of Ulanga was established gradually. The 1920s lead up to a first British Colonial Development Act (CDA) by the end of the decade.[6] Yet, Development at the time of this act was still understood almost exclusively in economic terms and bounded by the political principle that a colonial territories' development had its base in economic self-sufficiency. Therefore, at the time of the CDA, the local administrators were hoping to keep down all other costs so that they could concentrate on pushing agricultural development. Additionally,

[1] Helen Tilley, *Africa as Living Laboratory*, 2011, p. 11.
[2] For an introduction to the economy under German colonialism, see Thaddeus Raymond Sunseri, *Vilimani*, 2002. Classic for German colonial policies is John Iliffe, *Tanganyika under German Rule*, 1969; Helge Kjekshus, *Ecology Control and Econonomic Development*, 1977; Juhani Koponen, *Development for Exploitation*, 1994.
[3] Lorne Larson, *History of Mahenge*, 1976; Maia Green, *Priest, Witches and Power*, 2003, p. 18. Jamie Monson, *Commerce to Colonization*, in African Economic History, 1993. Maji Maji contained a strong element of resistance against trade: Lorne Larson, *History of Mahenge*, 1976, p. 110. Critically examining the discourses about periphery in Southern Tanzania: Pekka Seppälä, ed. *Making of a periphery*, 1998.
[4] Michael D. Callahan, *Mandates and Empire*, 1999; Michael D. Callahan, *Mandated Territories*, 2006.
[5] Boris Barth et al., *Zivilisierungsmissionen*, 2005; Walter Rodney, *How Europe underdeveloped Africa*, 1981 [1972].
[6] Rudolf von Albertini et al., *Dekolonisation*, 1966; Michael Havinden et al., *Colonialism and Development*, 1996, pp. 140-168.

the British had not much capacity and expertise that could be sent to a peripheral area like Ulanga, and thus the administrative staff would remain basically very underdeveloped for the entire period of British rule. Ulanga was soon plunged into the global economic crisis, and the colonial hope of transforming Ulanga into the bread basket of East Africa was far from being realized.[7] Still, British policies, as well as their limitations, were soon felt by the Swiss missionaries, who tried to get a foothold in Ulanga, and who used the field of medicine as a tool in this quest.[8]

The following chapter looks at this period and the missionary strategies employed. The historiography on medical missions in Tanzania contains several of the broader topics covered in this chapter.[9] 'Secular' and missionary medicine in Ulanga were heavily interconnected and often cooperated, as Michael Jennings has argued for Tanzania in general. Modern medicine was spread very thinly – and the same was true for colonial administration. Administrators and missionaries often found themselves in a similar position: they tried to establish some hold over an area that was unfamiliar to them, whose history and environment they did not understand, and whose languages and cultures, to the European, were, at first, exotic.[10] Nor were they aware of the indigenous means by which people maintained their health. African medicine was understood to be a set of magical practices incapable of addressing the true cause of disease. This colonial gaze grossly misread African concepts of healing, and ignored practices to establish a healthy environment. Colonial interventions often destroyed traditional practices in the field of health.[11] Instead, they saw their own medical knowledge as a potential tool to establish relationships with Africans. In addition, although we cannot be sure about the individual composition of the motives propelling this, colonial authorities and missionaries in general felt a sense of duty to apply this knowledge.

When they brought 'Swiss' medicine to Ulanga, missionaries felt that they entered 'the bush' as pioneers. Concomitant with Catholic missionary work with roots going back many centuries, it was really from the turn of the 19th century that Catholic 'mission medicine' was

[7] TNA 450/34/3 A.M. Clark, *Letter PC E.P. to DO Mahenge. 06.06.1929*; Alexander M. Telford, *Report on the development of the rufiji and Kilombero valleys*, 1929; C. Gillman, *South-West Tanganyika Territory*, in The Geographical Journal, 1927; Tanganyika Railway Commission, *Report of the Tanganyika Railway Commission*, 1931.
[8] Sr. Innozentia M. Hürlimann, *Briefe, 27.10.1931; 02.02.1932*, in Providentia, 1932.
[9] With particular importance to this chapter: Terence Ranger, *Godly Medicine*, 1992; Michael Jennings, *Healing of Bodies, Salvation of Souls*, in Journal of Religion in Africa, 2008; Walter Bruchhausen, *Practising Hygiene*, in Dynamis, 2003; Walter Bruchhausen, *Medizin zwischen den Welten*, 2006, pp. 333ff; Walter Bruchhausen, *Medicine Between Religious Worlds*, 2009.
[10] For an account of Swiss protestant missionaries see: Patrick Harries, *Butterflies and Barbarians*, 2007, chapter 2. For a comparison with Catholic missionaries coming to East Africa: Peter Pels, *Politics of Presence*, 1999, chapter 2.
[11] Steven Feierman et al., *Social Basis - Introduction*, 1992; Patrick Harries et al., *Medizin und Magie*, 2012; Stacey Langwick, *Bodies, Politics and African Healing*, 2011; Walter Bruchhausen, *Medizin zwischen den Welten*, 2006; Walima T. Kalusa, *Disease and the Remaking of Missionary Medicine*, 2003; Osaak A. Olumwullah, *Dis-ease in the Colonial State*, 2002; Charles M. Good, *Ethnomedical Systems*, 1987; Meredeth Turshen, *Political Ecology of Disease*, 1984; James Giblin, *Precolonial Politics*, 1996; Juhani Koponen, *Population: a dependent variable*, 1996. For historical African forms of prevention in Ulanga in a longue durée perspective see: Gloria Martha Waite, *History of Traditional Medicine and Health*, 1992.

established as a tool to heal and convert.[12] Mission medicine entered missiology books, it was presented to the readers of missionary journals, and not least it had been experienced by some of the people from Ulanga before the arrival of the missionaries from Switzerland. Missionary medicine was not a simple spiritual enterprise, but a multifaceted techno-social complex. This complex entailed, to name only some of the more visible aspects: the syringe, tents and hammocks, missionary dress complete with hoods and tropical helmets, dispensaries – places where drugs and treatment, but also food and care, were provided.[13] And, not least, it brought with it religion. Religion, conveyed through books and the spoken word, and, also songs, and by in the form of holy water, crucifixes, and icons and images. This chapter lays out how these things arrived in Ulanga as the endowment of the Mission, and how they gave the medicine of the Mission its particular form. Beyond that, this chapter describes how a 'modern' concept of welfare was developed by missionaries in Ulanga, a concept that had its roots in diverse practices drawn from Switzerland and the imperial world. The first major welfare institution that was brought to bear on the African population was a mixture of the poor-relief hospital together with new forms of medicine. Through these activities, the missionaries invented the idea of the African as the poor heathen in need of medical help and true care and healing.

## The Coming of Catholic Mission

### Benedictine Foundations

The Catholic Mission was a latecomer amongst the missionary movements in the period of high imperialism.[14] In German East Africa, the Catholic missions could establish stations in a number of areas. Since 1888, the Benedictine missionary congregation of St. Ottilien in Bavaria, with a branch in Switzerland (Uznach), had worked hard to establish their mission in the Southern parts of German East Africa.[15] They encountered many set-backs, some of them in Ulanga. A first attempt at establishing a mission station in the Mahenge hills was halted by African resistance and the consequent looting and burning of the mission station at Isongo in 1898.[16] The second major set-back was in 1905 when the *Maji Maji* uprising, which sprang from the area where the Benedictines had their mission station of Kipatimu, and its consequences wrought havoc on the whole region. The crushing of resistance by the German military resulted

[12] Ludwig Berg, *Christliche Liebestätigkeit*, 1935. Thomas Ohm, *ärztliche Fürsorge*, 1935. For the early history of missionary medicine, see Christoffer H. Grundmann, *Mission and Healing in Historical Perspective*, in International Bulletin of Missionary Research, 2008; Christoffer H. Grundmann, *Sent to heal*, 2005; Jean Pirotte et al., eds., *Eglises et Santé*, 1991, pp. 6-8. The Catholic pioneer on the African continent was Cardinal Lavigerie (and the 'White Fathers'): See François Renault, *Principes missionaires*, 1991; Aylward Shorter, *Cross and flag*, 2006.
[13] Nancy Rose Hunt, *Colonial Lexicon*, 1999.
[14] Catholic mission was almost exlusively French in Africa until 1885, even Irish missionaries were based on French connections. Bengt Sundkler et al., *A history of the church in Africa*, 2000, pp. 100, 107-108.
[15] Maia Green, *Priest, Witches and Power*, 2003, pp. 35-37. P. Laurenz Kilger, *St. Ottilien und die Schweiz*, in Katholisches Missionsjahrbuch der Schweiz, 1934. Siegfried Hertlein, *Von den Benediktinern zu den Kapuzinern*, 1997.
[16] Lorne Larson, *History of Mahenge*, 1976, p.63; *Die Schweizer Kapuziner in Afrika. Jahresbericht 1947*, 1947, pp. 7-8. Local histories seem to have termed this as "opposing Pogoro spirits": Michael Luka Mbago, *The impact of missionary education on the Pogoro of Mahenge district 1902-1946*, 1979, p. 29. He cites a local craftsman.

in the marginalisation of Ulanga in times famine, and probably in an elevated child mortality rate that lasted for several years after the war.[17]

By the 1910s the Benedictine mission had recovered from the destruction in the wake of *Maji Maji*. Based on a strategy of strong monastic centres (rather than individual travelling missionaries) and working alongside the sister congregation of Tutzing, the Benedictines of St. Ottilien claimed to have been more successful than Protestant missions at that time.[18] Certainly, the southern highlands area had come under very strong Catholic influence.[19] It was also an important achievement because it checked the Protestant Mission's influence in the west.[20]

The mission came into a dynamic area. The elements that – from the perspective of a social history of missions – were the important issues described by the Mission as 'missionary/mission problems' over the next few decades were manifold. Local competition for political rule and over alliances was vibrant. This competition was fuelled by the impact of colonial rule with its systems of local rule, by colonial trade and the regulation of rights of ownership, mobility which brought major shifts in the rural economy. The mission added its competition with Islam (and everything non-Catholic) to this, as well as the practical work of the Mission itself and what that entailed for the local population both in terms of new social services and lifestyles.

Ifakara, an outreach post under the monastic centre Kwiro, was considered by the Benedictines to be a station where Muslim 'encroachment' was especially strong – "outwardly a fully Islamic town".[21] Yet there was some success in pushing back the popularity of Islam, and Ifakara was centrally located, and – compared to Kiberege, where the British would run their administrative station in the area – Ifakara seemed to the missionaries to be less affected by labour migrating out to the plantations.[22] At the beginning of WWI, Ifakara had 15 mission schools and it had medical services in a 'blockhouse', where perhaps 400 patients were treated annually.[23]

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[17] James L. Giblin et al., *Maji Maji*, 2010; Jamie Monson, *Relocating Maji Maji*, in The Journal of African History, 1998; Gilbert Clement Kamana Gwassa et al., *The outbreak and development of the Maji Maji war 1905-1907*, 2005; Felicitas Becker, *Traders, Big Men and Prophets*, in Journal of African History, 2004; Heike Schmidt, *(Re)Negotiating Marginality*, in International Journal of African Historical Studies, 2010. Earlier accounts include: G. C. K. Gwassa et al., *Records of the Maji Maji rising*, 1967; UDSM Library John Iliffe et al., *Maji Maji resarch projects 1968: Mahenge town; Lupiro and environs (no.8 and no.9)*. and John Iliffe, *Tanganyika under German Rule*, 1969, pp. 162-156. Compare the latter with Lorne Larson, *History of Mahenge*, 1976, p.175ff. The argument about long term mortality is Larson's: Lorne Larson, *History of Mahenge*, 1976, pp. 133, 196.

[18] Josef Schmidlin, *Die katholischen Missionen in den deutschen Schutzgebieten*, 1913, p. 109.

[19] Maia Green, *Priest, Witches and Power*, 2003. Green uses the term "the persistence of mission" to denote the sustained influence of the (former) mission church on matters social, political and economic in the District of Ulanga.

[20] Marcia Wright, *German Missions*, 1971.

[21] Josef Damm, *Mission Ifakara*, in Missionsblätter. Monatschrift der Benediktiner-Kongregation von St. Ottilien und ihre Missionsvereins, 1917. The stationing of soldiers in the post Maji Maji phase was also given as a reason for the strength of Islam in Ifakara: *Die Schweizer Kapuziner in Afrika. Jahresbericht 1947*, 1947, p. 16. See for an account of the larger process of Islamization in Southern Tanzania: Felicitas Becker, *Becoming Muslim*, 2008.

[22] Josef Damm, *Mission Ifakara*, in Missionsblätter. Monatschrift der Benediktiner-Kongregation von St. Ottilien und ihre Missionsvereins, 1917.

[23] Josef Schmidlin, *Die katholischen Missionen in den deutschen Schutzgebieten*, 1913. On missionary strategy see p. 118. On comparison to evangelical missions, see p. 108. On stations in Ulanga see:p. 117. PADSM 153/5: P. Gallus Steiner, *50 Jahre Mission Ifakara. St. Andreastag 1911-1961*; PADSM 153/5: Hieronymus Schildknecht, *Vorgeschichte zur Gründung*

The mission health care services were not the only contact with the new medicine to be brought by the Europeans. We can assume that Government and military medical services in Mahenge extended some health care services to Africans – certainly during military campaigns.[24] Ulanga was a significant area of transit, where many must have seen or heard about the medical services that had been established on the coast and in the South. In Kilosa and in Dar es Salaam the government had opened hospitals for "non-Europeans" or "Natives" and missions had brought medical services to East Africa since the 1880s.[25]

The missionary investment in schools and, to a lesser degree, in health care as part of the endeavour to build and maintain Christian communities contributed to the local social dynamics in Ulanga in the early 20th century. It was not a local attempt, however, but was steeped in broader colonial and mission policies. Although with a very limited investment in education and welfare, colonial ideologies and policies went beyond simple extraction and looked towards a fully Eurocentric ideal of 'civilisation' and 'development' of Africans. Within this framework, Africans had a role to play, and even a degree of agency: John Iliffe has argued that after *Maji Maji*, there was an investment in an "age of improvement", in which "the literate [...] intermediary between European and African" became a new commanding figure, and his "personal improvement [...] was also a victory for his people".[26]

Mission work was linked with this process. In particular, what the Mission considered to be "Kulturarbeit", literally 'cultural work', contributed to the civilizing mission. "Kultur" was in the understanding of the time the things that produced a specific quality of man-made (material) life and it was set apart from the religious world falling under the ambit of the Church, which called for spiritual practice and perfection of the human being in the view of God.[27] Kulturarbeit was secular work, albeit that it happened within a clearly non-secular enterprise. Besides the religious work of mission, 'Kulturarbeit' qualified as the "secondary objectives", the missionary theorist Schmidlin explained in his fundamental work for Catholic Mission Studies. The mission

*der Mission Ifakara*. On medical services by the Benedictines see Franz Szczypior, *sozialwirtschaftliche Arbeit*, 1923, p. 258. Eduard Desax, *Entwicklungshilfe*, 1975, pp. 104-105.

[24] Hermann Fabry, *Aus dem Leben der Wapogoro*, in Globus, 1907. His report includes some observations on Wapogoro medicine.

[25] Helmut Goergen; Walter Bruchhausen; Kirsten Kuelker, *History of Health Care in Tanzania*, 2001; Patrick Thomas Malloy, *Holding by the Sindano*, 2003, pp. 171-183; Wolfgang U. Eckart, *Medizin und Kolonialimperialismus*, 1997, pp. 291-388. Terence Ranger, *Godly Medicine*, 1992. On the establishment of medical services by the Benedictines South of Mahenge see: Walter Bruchhausen, *Medizin zwischen den Welten*, 2006, pp. 308-314. An interesting special approach was chosen by the White Fathers who trained Africans as doctors, one of them Adrien Atiman: Aylward Shorter, *Cross and flag*, 2006, pp. 125ff.

[26] John Iliffe, *Tanganyika under German Rule*, 1969, pp 166-167. For the further career of this class see: Andreas Eckert, *Herrschen und Verwalten*, 2007.

[27] Although 'Kulturarbeit' is a widely used term at the time, it has never been well defined, and was used by Protestant and Catholic Churches alike (and also by the socialists likeTrotsky). But it was, for example, not entered into Heinrich Joseph Wetzer et al., *Wetzer und Welte's Kirchenlexikon*, 1882-1903. The term was of particular importance for the missions however: Ludwig Berg, *Die katholische Heidenmission als Kulturträger*, 1927. For a critical reading of Berg in terms of race see: Birthe Kundrus, *Moderne Imperialisten*, 2003, her discussion of 'acclimatization' p. 162ff. For the Catholic medical Mission: C. Becker, *Missionsärztliche Kulturarbeit*, 1928. For the protestant Basel Mission: Paul Steiner, *Kulturarbeit der Basler Mission in Westafrika*, 1904.

had to use 'Kultur' as a tool to approach the 'heathen', by mesmerizing them with 'benefactions' and by making 'them' fit for Christianity: "A certain level of culture is a necessary pre-condition for successful missionary work". If necessary, these cultural 'tools', like schools, hospitals or housing, could engage with the state or enter into political debates. But they had to "always remain tied to moral behaviour".[28] At the same time, 'Kulturarbeit' could replace sheer repressive force when it came to the suppression of social ills and thus construct a "favorable psychological disposition" in African culture.[29]

The Benedictine mission thus invested in their 'Kulturarbeit' in Ulanga before the War. In middle of 1917, the Benedictine Prior of Kwiro did not even mention yet the possibility of the War leading to the demise of the Ulangan branch of his mission organisation.[30] But a year later, the *Missionsblätter* of the Benedictines from St. Ottilien in Bavaria saw their "mission in ruins".[31] By that time the Benedictine convents were vacated because of the War. Only one priest was, for some time, able to stay behind as the director of the leprosarium which the Mission ran in Tabora, close to Kwiro.[32] The global War had cut the Christian communities off from their transnational network of benefactors in Germany and left them to look after themselves.[33]

## Capuchin Mission in East Africa

The end of WW I brought new impetus into the global Catholic missionary enterprise. Pope Benedict XV charted a way forward for Catholic missions. The encyclical *maximum illud* of 1919 set the Catholic mission apart from the colonial projects of the nation state. It asked the missionaries to act with a transnational Catholic identity and engage positively with local cultural and national characteristics.[34] At this time, Switzerland witnessed the start of a "mission spring".[35] Old and new organizations merged into a movement which felt called to address not only religious but also social questions, questions of 'Kultur', on a global scale. One of the

[28] Josef Schmidlin, *Katholische Missionslehre im Grundriss*, 1923 [1919], pp. 332-335, 341, 428-332. See for a very similar argument a manuscript by the Benedictine Erzabt Norbert Weber quoted extensively in Franz Szczypior, *sozialwirtschaftliche Arbeit*, 1923, pp. 8-9, 15-16. Eduard Desax, *Entwicklungshilfe*, 1975, pp. 59-60; John Iliffe, *Modern History of Tanganyika*, 1979, p. 358.
[29] Franz Szczypior, *sozialwirtschaftliche Arbeit*, 1923, pp. 8, 42.
[30] Eugen Feller et al., *Kwiro*, in Missionsblätter. Monatschrift der Benediktiner-Kongregation von St. Ottilien und ihre Missionsvereins 1917.
[31] *Missionsruinen*, in Missionsblätter. Monatschrift der Benediktiner-Kongregation von St. Ottilien und ihre Missionsvereins, 1918.
[32] *Missionsruinen*, in Missionsblätter. Monatschrift der Benediktiner-Kongregation von St. Ottilien und ihre Missionsvereins, 1918.
[33] The disruption in missionary supervision did not mean the total collapse of Catholic life in the area. Pirouet offered a clear-sighted analysis that puts missionary master narratives in perspective: M. Louise Pirouet, *East African Christians and World War I*, in The Journal of African History, 1978.
[34] Pope Benedikt XV, *Maximum Illud [Apostolisches Schreiben vom 30.11.1919]*, 1919. Josef Friemel, *Gründung*, in Neue Zeitschrift für Missionswissenschaft, 1975; Urban Schwegler, *Priestermission*, 2004. The duty to do mission work was again stated explicitly in Pope Pius XI, *Rerum Ecclesiae [Apostolisches Schreiben vom 28.02.1926]*, 1926. The Missionsbote dedicated a title story to this apostolic letter: 1926, number 10.
[35] Urban Schwegler, *Priestermission*, 2004, p. 418. Urs Altermatt, *Goldene Jahre*, 1994, pp. 3-5; Jacques Gadille et al., *Der neue Missionseifer*, 1997.

organizations joining and making this mission spring was the Swiss branch of the Capuchin order.

After the War 'German' organizations like the Benedictines were not easily allowed back into East Africa. As a response, the Roman Catholic Church decided that a large part of the area formerly assigned to the Benedictines was to be put under the custody of the Swiss Capuchins.[36] The Capuchins are a monastic order organised along the Franciscan ideal, which includes the vow of a life of material poverty. The Capuchins have a long tradition in Switzerland going back to the time of the early Counter-reformation.[37] From early on, the Capuchins worked amongst the common people. In the 16th and 17th centuries, they founded a large number of establishments. Towards the end of the 19th century, they gained fresh popularity and experienced a considerable growth which was sustained throughout the "blossom period"[38] of the Catholic milieu in Switzerland until the 1950s.

In 1921 the Swiss Province of the Capuchins proudly announced the "definite entry of Switzerland [by which they meant Catholic Switzerland] into the ranks of the missionaries".[39] Unlike the Missionary Benedictines, the Capuchins from Switzerland were not a mission-focused congregation.[40] The Swiss order had produced some famous missionaries, most notably Anastasius Hartmann, who had headed Catholic mission work in the Indian Dioceses of Patna and Bombay from 1846 and 1849 respectively.[41] But they had only recently sent individual missionaries to work in the Seychelles.[42] This had not yet led to an exclusively missionary structure among the Swiss Capuchins. Consequently, when they were sent to take over the Dar es Salaam and Ulanga mission sites in East Africa, they possessed little experience.[43]

Arriving in a totally new mission field in Tanganyika, all but two of the Swiss missionaries, who had done a couple of years of missionary work in the Seychelles, were totally inexperienced. The missionaries had to come to grips with the social environment in which they were about to work. They were either *Patres* – well trained in clerical matters, or *Brothers* – often well trained in professional skills like building works, carpentry and the like. They were rural people, recruited from the countryside of the Catholic cantons of Switzerland.[44]

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[36] Marita Haller-Dirr, *Bischof Gabriel Zelger*, in Helvetia Franciscana, 1995; Marita Haller-Dirr, *75 Jahre*, in Providentia, 1995. P. Otto Hophan, *Die ausländischen Missionen*, 1928; Brigitte Degler-Spengler et al., *Die Kapuziner und Kapuzinerinnen in der Schweiz*, 1974, pp. 43-44. The prefecture of Lindi was given to the Uznach Benedictines Hilarin Felder, *Zum Andenken an den Missions-Papst Benedikt XV*, in Jahrbuch des Akademischen Missionsbundes Universität Freiburg, 1922.

[37] The following section draws heavily on Christian Schweizer, *Kapuziner*, 2009, available under http://www.hls-dhs-dss.ch/textes/d/D11708.php.

[38] Urs Altermatt, *Katholizismus und Moderne*, 1989 [1991], p. 159.

[39] P. Guido Käppeli, *Die erste Schweizermission in Afrika*, 1921. It was to remain a reason for pride of "tiny Switzerland': A. Wild, *Jahresbericht des akad. Missionsbundes Freiburg*, in Jahrbuch des Akademischen Missionsbundes Freiburg, 1930.

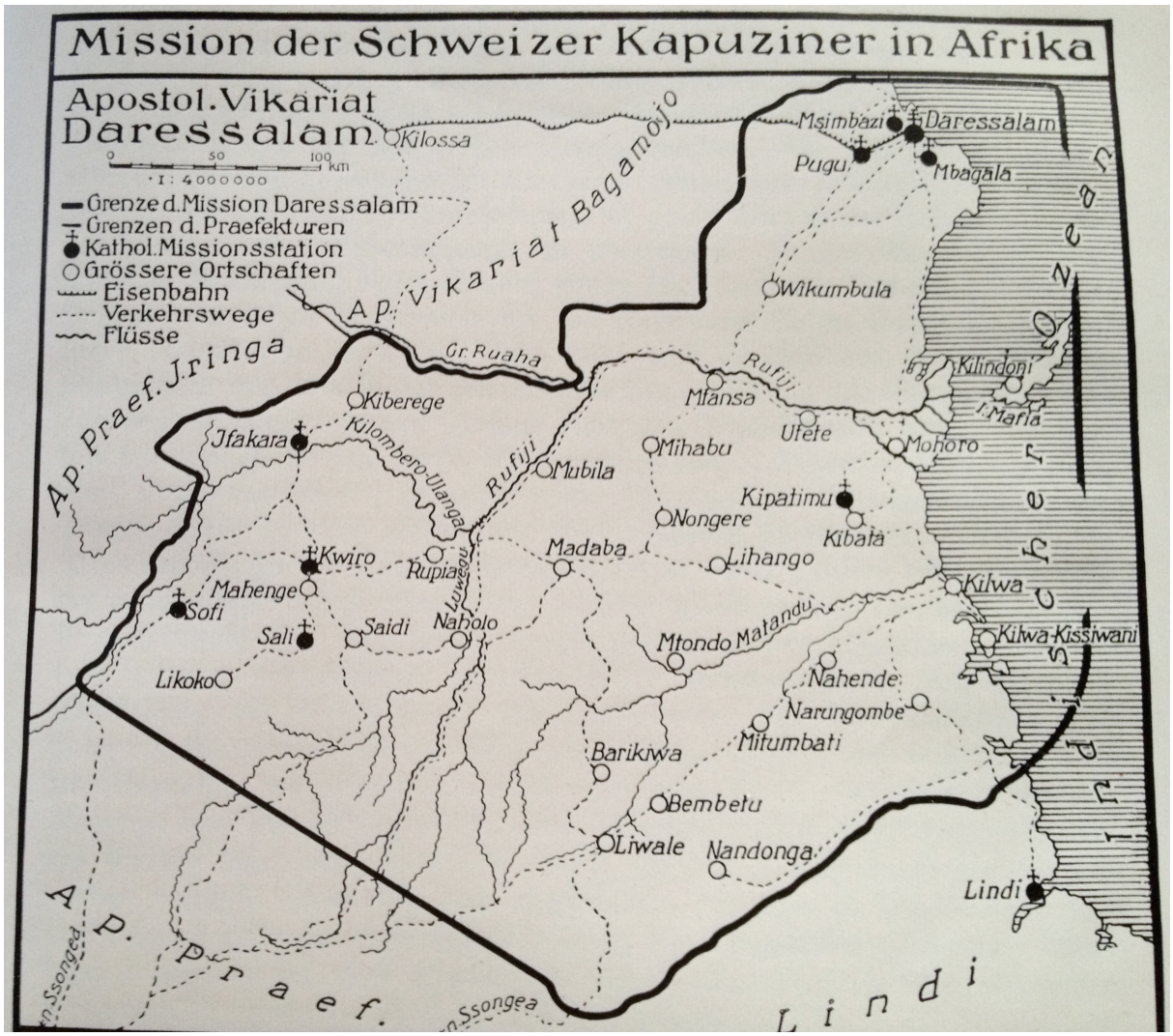
[40] Mentioning these tensions in allocating resources and staff between Switzerland and the mission: Ansgar Häne, *Missionsarbeit der Schweizerkapuziner*, in Katholisches Missionsjahrbuch der Schweiz, 1937.

[41] Walbert Bühlmann, *Pionier der Einheit*, 1966; Anastasius Hartmann, *Autobiographie*, 2003.

[42] Marita Haller-Dirr, *Bischof Gabriel Zelger*, in Helvetia Franciscana, 1995.

[43] The argument about the 'inexperience' is also made in Maia Green, *Priest, Witches and Power*, 2003, p. 40. See also Lorne Larson, *History of Mahenge*, 1976, p. 254.

[44] Marita Haller-Dirr, *Du schwarz, ich weiss*, 2012, pp. 42-43.




**Map: "Missionsgebiet" 1928[45]**

We do not know much about the missionaries' preparation for the mission field. Marita Haller-Dirr has appreciated the role of P. Adelhelm Jann, based at the Kollegium at Stans, in lobbying for a Swiss Catholic missionary movement. Jann pushed for a sort of a missionary will in the Swiss Catholic clergy. He organised the funding of such an enterprise, and also provided basic knowledge about the East African missionary field by editing mission reports from P. Hilarius Kaiser, a Benedictine priest who had been in the East African Mission.[46] With an article by the Capuchin Guido Käppeli, who was amongst the first missionaries to be sent to the East Africa mission, the newly established propaganda journal for the Africa Mission, the *Missionsbote,* introduced its sponsors in Switzerland to the new "Capuchin Mission in East Africa". P. Guido explained that the area, centred on Mahenge rather than Dar es Salaam[47],

[45] P. Anastasius Bürgler et al., *Schweizer Kapuzinerprovinz*, 1928.
[46] Adelhelm Jann, *Missionsberichte*, in Fidelis, 1921f. Marita Haller-Dirr, *Bischof Gabriel Zelger*, in Helvetia Franciscana, 1995, pp. 70-78.
[47] Coast and inland regions were geographically set apart from each other. From the mid 1920s this created conflict between the inland missionaries and the Bishop on the coast. Marita Haller-Dirr, *Bischof Gabriel Zelger*, in Helvetia Franciscana,

covered about a tenth of Tanganyika Territory, which meant it was two and a half times the size of Switzerland. He described its physical features as an African version of Swiss alpine foothills, with rivers named Ruaha and Kilombero, and mountains called Muhulu, and with a monastery capital on the mountain, Kwiro, which was reminiscent in its beauty and comfortable climate of the great Benedictine centre in Engelberg.[48] He glossed over the local agricultural products but listed colonial ones, declaring that rice grew plentifully enough to feed half of Europe, if only transport were available, and, last but not least, P. Guido did not forget to note the need to import altar wine through the White Fathers' connections in Algiers.[49]

P. Guido's report was based on tips from other missionaries and compiling secondary sources rather than on his own travels. His ethnographic information definitely reads as if it were copied from an encyclopaedia:

> "Apart from the coastal populations whose life has been Europeanized, we can make the following observations about the inhabitants in the interior. They no longer live in caves but mostly in round huts with superimposed roofs built from thatch [...]. The fact that food is plentiful allows the Africans' inborn laziness to reign. All of them believe in idols, and the wizard or medicine man or rainmaker is accountable for the sinister fear that keeps everyone in slavery. Furthermore, the African knows neither innocence nor the holiness of marriage, for the sinful manners inbred in the course of millennia weigh him down." [50]

The knowledge of these missionaries about Africans was a very sketchy, even if one makes allowances for the fact that such publications flattened out complexities for the sake of missionary propaganda.[51] Stereotypes and generalizations reigned. The Mission had chosen the "Wapogoro", as a consequence of their substantial presence in Kwiro, as the ethnic group to receive their foremost attention. They were, by this time, already tagged as 'lazy' and 'backward'.[52] 'Laziness' as a property of the 'heathen' and uncooperative Christians was a widespread concept in missionary discourse in Ulanga at that time.[53] Against this, the missionaries set themselves tasks to achieve in the creation of a work ethic:

> "Our duty it is not to train the minds first but to awaken the sense of the honor and virtue of work, in the manner that the Benedictines themselves have. Otherwise we shall end up with

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1995, 98-99. A missionary travel report in the region is Kunibert Lussy, *Mit Kino und Kugel: eine Film- und Jagdreise in Ostafrika*, 1934.

[48] The tourist destination of Engelberg has an impressive Benedictine monastery with a large school.

[49] P. Guido Käppeli, *Die erste Schweizermission in Afrika*, 1921.

[50] P. Guido Käppeli, *Die erste Schweizermission in Afrika*, 1921.

[51] For a critical approach to the Capuchin missionary imagery of the African see Marita Haller-Dirr, *Du schwarz, ich weiss*, 2012.

[52] Gillman reported that the Wapogoro were one of the most backward tribes, a discourse still in place in the mid 1960s and was still given as an obstacle for development projects in the early 1980s: C. Gillman, *South-West Tanganyika Territory*, in The Geographical Journal, 1927; Louise Mathilde Aall-Jilek, *Epilepsy in the Wapogoro Tribe in Tanganyika*, in Acta Psychiatrica Scandinavica, 1965; BAR E2025A 1993/130 T. 311 Tansania.27: *Ulanga Kombinationsprojekt (Swissaid)*. Missionaries have produced a rich ethnographical literature on the ethnic groups in Ulanga and Kilombero. A listing of works up to the early 1950s in A. Brantschen, *Die ethnographische Literatur über den Ulanga-Distrikt*, in Acta Tropica, 1953. Kunibert Lussy et al., *Religiöse Anschauungen und Bräuche bei den Wapogoro*, in Anthropos, 1954; Ladislaus Siegwart, *Die Arbeitsteilung bei den Pogoro*, 1954; Gregorius P. OFMCap Van den Boom, *Die Wandamba (Tanganyika)*, in Anthropos, 1964. Largely based on missionary ethnography is Sidonius Schoenaker, *Hintergründe*, 1965.

[53] Wolfram Meyer, *Poesie und Prosa des Missionslebens [Auszüge aus seinem Tagebuch]*, in Providentia, 1929; PADSM 153/3: *Chronik von Ifakara. Januar 1931-Pfingsten 1933*. Very colonial: P. Jesuald Loretz, *Volk und Boden*, in Missionsbote der Schweizer Kapuziner in Afrika, 1934. See for a discussion of (German) colonial discourse on lazyness Anton Markmiller, *Erziehung*, 1995. The discourse on laziness goes back to the times of slavery, see Walter Rodney in John Donnelly Fage et al., *The Cambridge history of Africa*, 1975, p. 616.

> a generation of dawdlers and layabouts. To sit around in school or to fill the Church is not as difficult as taking to labouring with the hoe, which needs ceaseless exercise."[54]

Here was the laying out of a secular field where intervention was necessary and possible.[55] It was important to the Missions to show that there it would be possible to civilize the 'heathen' who fell under their mission.[56] Soon, the missionaries began to see advancement and culture as a question of knowledge. "Since my arrival," P. Philemon Maytain wrote in 1927, "I have come to revise many of my first impressions." For him, the "Negro was as intelligent as any white person [...but] he lacked a sense of cultured concepts about nutrition, habitation, marriage and this hindered the development of his mind."[57] The missionaries now described the problems of African societies as linked to the "economy of slave-work", in which women in particular were exploited primarily in the polygamous family, and the criticized the African religious authorities.[58] The Missionaries also developed an ambivalent view on colonialism.[59] This understanding made "Kulturarbeit" all the more of a prerequisite to Christianity. P. Philemon's statement also shows that the doors were open for a more scientifically based "interventionist colonialism" which would address a broad spectrum of secular issues.[60]

## Mission Medicine: "Missionsärztliche Caritas"

### Medicine, welfare and rural governance

In the interwar period, colonial medicine underwent a period of substantial change. Michael Worboys calls this new era the phase of "colonial health and welfare".[61] The state started to assume a role in sustaining the health of rural populations. While a policy of economic self-sufficiency was still being pursued, the health and welfare of the 'Natives' became a theme of colonial policies and, increasingly, a moral issue to be solved with the help of science.[62] Health became a topic of rural governmentality, binding the interest of the state and the subject.[63] While

[54] P. Guido Käppeli, *Mein Hochwürdiger P. Provinzial. Kwiro, 08.06.1922*, in Missionsbote. Missions-Nachrichten der Schweizerischen Kapuzinerprovinz, 1922.
[55] This was a typical component of 'Kulturarbeit': Sebastian Conrad, *Eingeborenenpolitik*, 2004, pp. 107-108.
[56] Richard Hölzl, *Rassismus, Ethnogenese*, in WerkstattGeschichte, 2012, p.18.
[57] P. Philemon Maytain, *Neger*, in Jahresbericht der Schweizer Kapuziner in Afrika 1927, 1927.
[58] *Die Schweizer Kapuziner in Afrika. Jahresbericht 1925*, 1925; P. Emmanuel Odermatt, *Islam und Neger*, in Seraphisches Weltapostolat des Hl. Franz v. Assisi, 1929/1930; P. Ansgar Häne, *Aus dem religiösen Leben der Neger*, in Seraphisches Weltapostolat des Hl. Franz v. Assisi, 1929; P. Oskar Kessler, *Aus dem Pori (Busch): Eine Teufelsaustreibung*, in Seraphisches Weltapostolat des Hl. Franz v. Assisi, 1931; P. Hieronymus Schildknecht, *Mädchenerziehung in Ostafrika*, in Seraphisches Weltapostolat des Hl. Franz v. Assisi, 1932.
[59] The Mission was presented as a crusade, not a colonial occupation: P. Jesuald Loretz, *Volk und Boden*, in Missionsbote der Schweizer Kapuziner in Afrika, 1934. In the 1940s the 'Catholic' view of Salazar, in a speech from 1933 [sic!] was presented to the Swiss audience in: Antonio de Oliveira Salazar, *Katholische Kolonialpolitik*, in Missionsbote der Schweizer Kapuziner in Afrika, 1944.
[60] Helen Tilley, *Africa as Living Laboratory*, 2011, in particular p. 11.
[61] Michael Worboys, *Colonial Medicine*, 2003; Michael Worboys, *Colonial World as Mission and Mandate*, in Osiris, 2nd Series, 2001.
[62] John L. Comaroff et al., *Ethnography and the Historical Imagination*, 1992, pp. 215-233; Helen Tilley, *Africa as Living Laboratory*, 2011; Joseph Morgan Hodge, *Triumph of the Expert*, 2007. See also chapter 4.
[63] Michel Foucault et al., *Geschichte der Gouvernementalität*, 2004.

welfare and rights-based social services were never going to take priority over established interests in sanitized labour and in segregation as sanitation, from the perspective of the rural areas it still introduced the presence of the state in a much more permanent manner.[64] This was a bifurcated process, as Nancy Rose Hunt powerfully argued in a talk in 2011: The "two-faced state" was moodily changing between a nervous, security-oriented and a biopolitical-humanitarian stance vis-à-vis the Africans.[65]

## Catholic mission medicine

Missionary medicine's raison d'être was the facilitation of contact with as many people as possible. Indeed, it offered numerous points of contact, and many of them were very close.[66] But Catholic mission medicine had been late in coming to this area. Schulpen cites the discussion among the heads of all Catholic Missions in Tanganyika in 1928 that the "Protestants are far ahead in medical work and the ground lost has to be re-conquered."[67] When Catholics in Switzerland founded their Association for Medical Missions in 1926, the keynote speaker addressed the fact that there were supposedly 2,000 Protestant, against only 13 Catholic, medical doctors worldwide.[68]

The framework for mission medical work by German-speaking missions was established by Christoph Becker, the founder of the Missionsärztliche Institut in Würzburg.[69] During a missionary exhibition in 1932, the Swiss Association for Missionary Medicine described the seven functions of the mission doctor:

> "He has a calling as a protector of the mission staff; as a gracious Samaritan to the native; as a spiritual trailblazer for the missionary; as a bearer of the flag against deplorable customs and amorality; as a sponsor of culture and hygiene; as a worldly guardian angel of the 50-80% of babies facing death; and finally in the form of a female missionary doctor she is often the only provider of help to the heathen woman."[70]

This view was based on the experience of the encounter of the missionary with the 'heathen':

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[64] Myron J. Echenberg, *Black Death, White Medicine*, 2002; Maynard Swanson, *Sanitation Syndrome*, in Journal of African History, 1979; Philip Curtin, *Medical Knowledge*, 1992. A telling example about health of labor was the debate in 1930 between the labor commissioner and the Director of Medical Services whether sanitation on the estate, or strict, if necessary ethnic, control in labor migration was necessary: TNA 61/231/2: G.H. Orde-Browne, *Letter Labour Commissioner Morgoro to Chief Sec. Morogoro 27.01.1930*.

[65] Nancy Rose Hunt, *Suturing new medical histories* (Basel, 2011). Forthcoming as a Carl Schlettwein Lecture publication.

[66] Christoffer H. Grundmann, *Sent to heal*, 2005; John L. Comaroff et al., *Revelation and Revolution II*, 1997, chapter 7.

[67] T. W. J. Schulpen, *Integration of Church and Government Services*, 1975, p. 47; David Hardiman, *Introduction*, 2006, p. 24. It was also true for the German missions: *Statistik*, 1935.

[68] P. Odorich Koch, *Missions-Ärztliche Fürsorge*, in Missionsbote der Schweizer Kapuziner in Afrika, 1927. Not a single Catholic Mission doctor came to Tanganyika before World War I. Wolfgang U. Eckart, *Medizin und Kolonialimperialismus*, 1997, pp. 291-388. Terence Ranger, *Godly Medicine*, 1992. An interesting special approach was chosen by the White Fathers who trained Africans as doctors, one of them Adrien Atiman Aylward Shorter, *Cross and flag*, 2006, pp. 125ff.

[69] C. Becker, *Missionsärztliche Kulturarbeit*, 1928; C. Becker, *Ärztliche Fürsorge in Missionsländern*, 1921. On the institute see chapter 6.

[70] Friedrich Kürner, *Schweizerischer katholischer Verein für missionsärztliche Fürsorge*, in Katholisches Missionsjahrbuch der Schweiz, 1935.

> "One of the best ways to earn the trust of the people is the dispensing of medicine to the sick ones. Because all the natives think of any missionary as a sort of doctor, they come very quickly to the mission for help."[71]

The general argument for mission medicine in the public therefore was that it was a tool for mission, in the words of Sister Bernadette Gabler of the Baldegg Sisters, it was a "means to approach" the subjects of the mission.[72] Going beyond the corporeal, Mission medicine established a triangular and mediated relationship between God, the missionary caregiver and the heathen. The 'mission greeting card', produced by the Catholic Swiss Association for Mission Medicine in 1932 which was in use for many years, presented this very clearly.[73]


**"The image is self-explanatory", says the caption to the advertisement card produced on behalf of the Catholic Swiss Association for Mission Medicine. Reproduced from: Missionsärztliche Caritas 1935.**

[71] P. A., *Bilder aus dem Missionsleben*, in Missionsbote. Missions-Nachrichten der Schweizerischen Kapuzinerprovinz, 1923. Similar: *Krankheit und Krankenpflege in unseren Missionen*, in Missionsbote der Schweizer Kapuziner in Afrika, 1924.
[72] Sr. Bernadette Gabler, *Die Sorge um unsere kranken schwarzen Bürder und Schwestern im Apostol.Vikariat Daressalaam (Ostafrika)*, in Missionsärztliche Caritas, 1935.
[73] Friedrich Kürner, *Missionsärztliche Fürsorge (40 Jahre Schweizerischer missionsärztlicher Verein)*, in Missionsärztliche Caritas, 1966.

Mission medicine always brought about close connections between religion and the material world. The role that missionary medicine had in the Capuchin mission was clearly stated by the head of the Capuchin mission, Edgar Maranta:

> "An ordered religious life is conditioned on an ordered natural life. The dull manner in which the natives endure their suffering contributes to their total mental demise and obviously have no more interest in faith. Only when their physical health is re-instated, they awake to new life." [74]

Maranta's statement on the importance of livelihoods and health captures the raison d'être and programme of the Capuchin mission's "Kulturarbeit" including medicine. We also note how it binds mission medicine to the spiritual tasks of the mission.

The man who steered the Capuchin mission in East Africa personified the practical approach of the Mission to the material world. Bishop Edgar Maranta (born Aristide Maranta) was energetic and hands-on, "practical by nature", and he was authoritative and conservative in church matters, proudly Swiss, but also diplomatic, talented in languages and he had a sense of humor.[75] Maranta was a specialist in education and would foster the mission schools and education programmes, and liaise with government for the support of these institutions. Maranta would eventually have, according to the secretary who worked closely with him during the 1960s, three hobbyhorses: the Tanzanian Episcopal Conference (TEC), a children's home in Msimbazi and the St. Francis Hospital in Ifakara.[76]

He had a meteoric career in the Capuchin Mission. He had come to Tanganyika in December 1925 as a young man of 28 years, and was a Bishop and head of the Mission at 33.[77] In the late 1920s, the Mission was in a crisis and their head, Bishop Gabriel Zelger, returned to Switzerland.[78] After a short interlude, Edgar Maranta was appointed Bishop and Apostolic Vicar of Dar es Salaam and he became head of the Mission. In 1936 he became Chairman of the Standing Catholic Education Committee which was a precursor to the Tanzanian Episcopal Conference which he was to head into the period of early independence as chairman from 1956-66.[79] Maranta returned to Switzerland in 1969 and died in Sursee in 1975.[80]

But we must remain cautious when we observe the material aims and the 'secular' medical practice of the Mission. Even if it used the same technical means as 'secular' medicine,

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[74] The bishop is quoted from a letter in: Sr. Bernadette Gabler, *Die Sorge um unsere kranken schwarzen Bürder und Schwestern im Apostol.Vikariat Daressalaam (Ostafrika)*, in Missionsärztliche Caritas, 1935. Maranta repeated almost the same statement in 1966: PAL Sch 1061.6: Edgar Maranta, *Letter to E. Mchonde. DSM 21.06.1966*.

[75] P. Hilmar Pfenniger, *Erzbischof Maranta ist tot*, in Ite, 1975. A good description of Maranta in: Walbert Bühlmann, *Überraschungen meines Lebens*, 1994, pp. 77-83. For an example of his sense of humor even in a difficult situation: PAL Sch 1061.5 Mappe 4 darin "tempus 1943": Edgar Maranta, *Letter to P. Manfred. DSM 19.07.1943*.

[76] P. Edelwald Steiner, *Das Porträt des Erzbischofs*, in ite, 1969; P. Edelwald Steiner, 2010.

[77] Edgar Widmer, *Dilecto filio....[Edgar Maranta] Evangelizzazione e opere per lo sviluppo*, 1980; Sr. Grace Shembetu, *Maranta*, 2000. Maranta has an entry written by the archivist of the Swiss Capuchins, Christian Schweizer, in the Historisches Lexikon der Schweiz: http://www.hls-dhs-dss.ch/textes/d/D9946.php

[78] Marita Haller-Dirr, *Bischof Gabriel Zelger*, in Helvetia Franciscana, 1995, pp. 99-103.

[79] PA Widmer Documents re Evangelizzazione e opere per lo sviluppo: *Edgar Maranta Archbishop 1930-1969. Archbishop Maranta and his role in the Tanzania Episcopal Conference*.

[80] P. Hilmar Pfenniger, *Erzbischof Maranta ist tot*, in Ite, 1975; Edgar Widmer, *Dilecto filio....[Edgar Maranta] Evangelizzazione e opere per lo sviluppo*, 1980.

mission medicine was not simply a private sector health care provider. Catholic Mission medicine had a political and moral economy of its own. Its work was steeped in Catholic traditions that ideally connected care givers and patients in non-capitalist ways. One tradition was that of *Caritas* - where particularly the nun-nurse had become a symbol of the religious care tradition and where redemption came to the person giving care as much as it came to the person receiving it.[81] Bishop Maranta told young nuns in Baldegg in 1950 that "Those who give to God may fairly expect God to repay a hundred times, as it has been promised in the Gospel".[82] A sort of religious accounting was in place, which was often presented as being more important than fame in this world (although being a mission person was a sure way to earn fame in one's own home community). "God alone knows," Sister Margrith noted, "what an impossible amount of pain was lifted [by the nursing care]. Also, He counts every single trip into the African huts, under the blazing tropical sun, crossing torrential rivers, swamps and marshland."[83]

But the Mission could not run on spiritual currency alone. It also needed to keep its house in order financially. Convents were organized on a very communitarian basis, but it was not a co-operative of owners: the individual lived in poverty, all secular possessions were with the congregation. It was important and difficult to manage the finances in a careful and sustainable manner. Frugality was a value that was ever-present. However, Maranta warned the sisters not to have a "shopkeeper attitude". Avarice and acquisitiveness were not acceptable. Since the late 19th century, the Catholic Church had sought a careful compromise with capitalism, but it also made sure that wealth had to be used in ways that were morally correct.[84]

"Caritas" became the key term for Catholic care and welfare from the early 20th century.[85] The Capuchins played an important role in the caritas-movement in Switzerland from the 19th and the early 20th century, and they were often the founders of important institutions and organizations of social welfare.[86] A Capuchin priest (P. Rufin Steimer) was the founder of Swiss "Caritas" in 1901.[87] This organization collected money to run social welfare programs (at first in

[81] Clemens Brentano, *Die Barmherzigen Schwestern in Bezug auf Armen- und Krankenpflege*, 1912; Alfred Fritschi, *Schwesterntum*, 2006 [1990], p. 47; Annelies van Heijst, *Models of Charitable Care*, 2008.
[82] Edgar Maranta, *Professspredigt in Baldegg*, in Providentia, 1950. The first Baldegg sisters leaving for East Africa were presented with a poem on the occasion of their departure. It contained the message: "whatever you sacrifice for God, will be returned twice." PADSM Box 332 Baldegg Sisters historical notes: *Den Missionsschwestern zum Abschied*.
[83] Sr. M. Margrith Bösch, *Schwesternarbeit in der Mission*, in Providentia, 1934.
[84] Aram Mattioli et al., *Katholizismus und Soziale Frage*, 1995, pp. 9-13, the quote from p. 11. Encyclica Quadragesimo anno, 1931, for example in section 71.
[85] Brian Pullan, *Catholics and the Poor in Early Modern Europe*, in Transactions of the Royal Historical Society (Fifth Series), 1976. Erwin Gatz, *Caritas und soziale Dienste*, 1997, p. 21. The overseas missions are absent in the book edited by Gatz, which otherwise explains the history of *caritas* in the German-speaking countries nicely. "Caritas" is often translated as charity in English bibles, in the Tyndale Bible also as "love" (Supriya Guha pointed this out to me). I stick to the term as it was and is still sometimes used in germanophone Catholicism. I would consider "Barmherzigkeit" as the best, although old-fashioned, term in German, with a strong note of the English "compassion". In the 1930s "Fürsorge" or "Liebestätigkeit" was used by Ludwig Berg, *Christliche Liebestätigkeit*, 1935; Thomas Ohm, *ärztliche Fürsorge*, 1935.and the Swiss Association for Medical Mission (at that time the "Schweizerischer Verein für Katholische Missionsärztliche Fürsorge"). *Caritas* catches both the moral as well as the concrete dimension of the act.
[86] Urs Altermatt, *Von der katholischen Milieuorganisation*, 2002, p. 16; Erwin Gatz, *Caritas und soziale Dienste*, 1997, pp. 227-232.
[87] Stephan Oetterli, *Schweizerischer Caritasverband* 2002; Susi Fehr, *Caritas als Liebestätigkeit*, 1951.

Switzerland only, but later as a form of development cooperation) and proposed that *caritas* was encompassed more than just humanitarian work, as it was firmly based on the spiritual disposition of the donor.[88] The Swiss Association for Medical Missions named its annual publication, established in 1935, "Missionsärztliche Caritas". The name of the publication, which in English would translate as: "the charity of mission medicine", conveys the spirit of the programme. The organization assembled medical doctors, priests, Catholic intellectuals and other kinds of supporters interested in this particular field of activity within the practice of *caritas.* As an idea and value, *caritas* played a role in constituting Catholic sociability from early in the history of Christianity. As a marker of identity, organizations practicing 'caritas' played a role in the Catholic "separate society" within the liberal Swiss Federal state. This society was characterized by a 'complex network of a myriad of organizations and institutions that sustained a life in a Catholic Ghetto', as Altermatt has powerfully expressed it.[89]

This Catholic-conservative movement in Switzerland had mustered its forces since the 1830s in political and social movements organized around the clergy, but sometimes taking the character of 'movements of young women'.[90] Social welfare work, education, and health care were important fields of activity of the movement that constructed the segregated Catholic society on the basis of numerous organizations which were meant to capture all aspects of everyday Catholic life.[91] One of the prominent examples are the sisters from the convent in Baldegg in the rural hinterland of Luzern.

## Mission Medical Practitioners

### Sisters from Baldegg

An essential element of the missionary enterprise was the need for female co-workers to help the celibate, Catholic, male missionaries: “Substantial and sustainable [Catholic Missionary] work is practically impossible without the cooperation of Sisters, who can draw girls and women to Religion and work and who can care for the numerous sick Africans."[92] Before they even sent out the first missionaries from Switzerland, the Capuchin order entered into a contractual relationship with the Congregation of the *Sisters of Providence* from Baldegg. The contract signed on 25 April 1921 stated that the Baldegg Institute “provides sisters to the mission”. The Mother General retained, according to the contract, full control over all matters relating to the selection

[88] Stephan Oetterli, *Schweizerischer Caritasverband* 2002, p. 69.
[89] Erwin Gatz, *Caritas und soziale Dienste*, 1997, pp. 23-26; Urs Altermatt, *Weg der Schweizer Katholiken*, 1972, here pp. 20-21, 25-27.
[90] Relinde Meiwes, *Kathoische Frauenkongregationen*, in L'Homme, 2008, pp. 40-42.
[91] Urs Altermatt, *Katholizismus und Moderne*, 1989 [1991], in particular pp. 63-71; Esther Vorburger-Bossart, *Bedürfnis der Zeit*, 2008.
[92] P.V. et al., *Unsere Missionäre in Afrika*, in Missionsbote. Missions-Nachrichten der Schweizerischen Kapuzinerprovinz, 1921, p. 2.

of sisters, their placement and assigned tasks. The mission offered spiritual leadership to the sisters, and carried the cost for travel and living.[93] The Baldegg congregation was not a bit more experienced in mission work than the Swiss Capuchins. Although it was one the oldest of the modern congregations in Switzerland, Baldegg had never previously sent any of their members abroad.[94]

The Baldegg convent was started in 1830 with a small group of sisters as the first female community to be active in the education of rural girls in Switzerland.[95] One of the aims and activities of the congregation in the rural parts of the canton of Luzern was "social-charitable" work including the care for the sick.[96] This foundation followed the model of St Vincent de Paul's "Sisters of the divine providence of Ribeauvillé". The young Swiss congregation faced many difficulties in its early decades, particularly in the 1850s when the anti-Jesuit movement also put Baldegg in danger. From about the 1860s, the community extended its religious and congregational character. In 1906 Baldegg became incorporated into the Capuchin order. In the early 20th century, the Baldegg community grew extensively up to about the 1960s, when recruitment abated. During the time of its growth the Baldegg sisters opened many associated institutions including a training school for nurses at Baldegg.[97] Until the first decades of the 20th century, nurses' training was relatively unregulated in Switzerland.[98] In the 1890s, the Baldegg sisters saw the need to provide a specialized training for those sisters engaged in care work at the homes of patients. The training included knowledge about herbal teas, and emphasized domestic duties.[99] From 1903, Sr. Angelina Hodel headed the nurses' training school and organized a professional curriculum, complete with its own teaching books.[100] These books represent the scope of training at the school: her first on the domestic care, a second one on the care of children, before she wrote a book on the general nurses' training of 850 pages and another on drugs. In her own words, Hodel was rigorous as teacher, and as a manager of the training school she adjusted the curriculum to the point where it was accepted by the Swiss Red

[93] PAL Sch 1043/Missionssekretär & Baldegg u. einzelne Schwestern: *Anhang 2 [zu was?]. Vertrag zwischen der Schweiz Kapzinerprovinz und dem Schwesterninstitut Baldegg. Luzern, 25.04.1921*. Marita Haller-Dirr, *Bischof Gabriel Zelger*, in Helvetia Franciscana, 1995, pp. 76-78.
[94] The Menzinger sisters were active in South Africa since 1883: Valentin Beck, *Kreuz des Südens*, in Schweizerische Zeitschrift für Religions- und Kulturgeschichte, 2010; Rudolf P. Henggeler, *Das Institut der Lehrschwestern vom Heiligen Kreuze in Menzingen (Kt. Zug), 1844-1944*, 1944.
[95] Esther Vorburger-Bossart, *Bedürfnis der Zeit*, 2008, pp. 90-93, 108-109; Waltraud Hörsch, *Baldegg (Kloster)*, 2009; M. Matthäa Vock et al., *Schwestern-Institut Baldegg*, 1930; Marianne-Franziska Imhasly, *Aspekte*, in Helvetia Franciscana, 1998; Brigitte Haselböck, *"Eine treue Dienstmagd im Weinberg des Herrn...": das Schwesterninstitut Baldegg, 1830-1880*, 1991.
[96] M. Matthäa Vock et al., *Schwestern-Institut Baldegg*, 1930, pp. 205-215.
[97] Waltraud Hörsch, *Baldegg (Kloster)*, 2009. Marianne-Franziska Imhasly, *Aspekte*, in Helvetia Franciscana, 1998; Maria Martine (Sr. Martine) Rosenberg, *Baldegger Schwestern*, 1998.
[98] Alfred Fritschi, *Schwesterntum*, 2006 [1990]; Sabine Braunschweig et al., *Professionelle Werte pflegen*, 2010.
[99] Institutsarchiv Baldegg B V 21.1: *Pflegerinnenschule [Chronologie]*; M. Matthäa Vock et al., *Schwestern-Institut Baldegg*, 1930, p. 206.
[100] M. Matthäa Vock et al., *Schwestern-Institut Baldegg*, 1930, pp. 207-208. Hodel's biography is unwritten. She seems to have been a powerful intellectual with a great interest in medical science and in its teaching and popularization (the popular version of her book on the care for the sick was printed in 10'000 copies). Institutsarchiv Baldegg B V 21.1: Sr. M. Angelina Hodel. Sr. M. Angelina Hodel, *Lehrbuch der Krankenpflege*, 1927 [1916].

Cross Society in 1917. The Baldegg training in nursing thus became professionalized while nursing as a profession was secularized.[101] From that moment, Baldegg gave out professional nurses' certificates and the Swiss state sponsored the training.[102] Nurses would go back and forth from their theoretical training in Baldegg and their practical training in one or more of the Catholic hospitals where Baldegg sisters were active.[103] By the end of the 1920s, about a third of all Baldegg sisters worked in health care.[104] Only a small number of these sisters went to the missions.

On the other hand, the community of Swiss Sisters did not consist only of nurses. A group of sisters shared the tasks at a mission station and the mother house in Switzerland supported them. Only a fraction of the large congregation went into missionary service, but those who went reported back to Switzerland and profited from the efforts of the entire congregation to collect goods and money for the Mission.[105] In the late 1940s, Sr. Gerda carefully crafted a report that highlighted how the Mission had amalgamated the skills and talents of Catholic Switzerland in Africa: "Walliserkraft" [the strength of Wallis], "Luzernerhände" [the hands/skill of Lucerne], "Baslerhumor" [the humor of Basel], the "kernige, gerade Natur aus den Bündneralpen" [healthy, genuine nature of the Grisons Alps] or a "hageres St. Gallergeissli" [a lean mountain goat from St. Gallen] were the terms she used to evoke a proud picture of federal Switzerland's strengths.[106] It is not my intention to analyze the social composition of the Baldegg sisters, but most of them had come from a simple farming background.[107]

Leaving home for the mission was regarded as a personal ordeal.[108] Many of the first reports in both the *Missionsbote* and the *Providentia* related accounts of the travels of the missionaries, their departure from Switzerland and then from Europe and their arrival in Africa and the manner in which they travelled into the interior.[109] It was certainly a challenge to leave the larger community for a life under the gaze of the male parish priest in relative isolation from

[101] Alfred Fritschi, *Schwesterntum*, 2006 [1990], p. 158; Relinde Meiwes, *Kathoische Frauenkongregationen*, in L'Homme, 2008. Nursing has been shaped by the Catholic congregations' motherhouse system, which informed the Kaiserswerth training institution, which in turn, became the global training model for nursing in the mid 19th century: Aeleah Soine, *Motherhouse and its Missions*, 2013; Claudia Bischoff-Wanner, *Frauen in der Krankenpflege*, 1997, pp. 126-127; Todd H. Green, *Responding to Secularization*, 2013.

[102] Institutsarchiv Baldegg B V 21.1: Sr. M. Angelina Hodel; Institutsarchiv Baldegg B V 21.1: *Pflegerinnenschule [Chronologie]*; Institutsarchiv Baldegg B IV 11,1: *[file] 1915-1934 Pflegerinnenschule Baldegg: Korrespondenz und Akten etc* The curriculum in 1930s is printed in M. Matthäa Vock et al., *Schwestern-Institut Baldegg*, 1930, pp.208-209; Alfred Fritschi, *Schwesterntum*, 2006 [1990], p. 80.

[103] An example of a diploma giving details for one of the sisters active in Tanganyika:TNA Acc.450/HE/178/16: Institut Baldegg, *[Translation of certificate of training, Sr. M. Innocentia Huerlimann]*.

[104] 170 in Switzerland. Paul Pflüger, *Der Krankenschwesternstand in der Schweiz*, 1929, pp. 8, 133.

[105] *Afrika / Baldegg*, in Providentia, 1932. *Baldeggs Heidenkind-Aktion*, in Providentia, 1932.

[106] Schwester M. Gerda, *Unsere Missionsschwestern in Africa*, in Providentia, 1948.

[107] A good overview on this yet underdeveloped issue with examples from Switzerland in: Esther Vorburger-Bossart, *Bedürfnis der Zeit*, 2008, pp. 33-36. For Germany: Relinde Meiwes, *Arbeiterinnen des Herrn*, 2000; Gertrud Hüwelmeier-Schiffauer, *Närrinnen Gottes*, 2004.

[108] PADSM Box 332 Baldegg Sisters historical notes: *Den Missionsschwestern zum Abschied*. For a recent study on Catholic sisters going into mission service and touching on many of the issues in this paragraph see: Katharina Stornig, *Sisters Crossing Boundaries*, 2013.

[109] See for example for Sr. Arnolda's trip: *Aus den Missionen*, in Providentia, 1929. Travel reports constitute a veritable genre and can be read as a reflection of the liminal moment of crossing the sea to Africa. Certainly they were also the result of the prolonged free time during the long journeys on board of the steamships.

the 'mother house'.[110] Some sisters probably experienced a sort of liberation in the discovery of the larger arena in which they could excel in practical work. Nevertheless, going into the mission field certainly presented a major challenge to any personality. Sr. Eucharis, the youngest of a batch of missionary sisters who left Switzerland in 1926, reported that missionary work in East Africa did not match her expectations, since many of her tasks put her, at best, into indirect contact with the heathen souls. Many of the chores were the same as those in any Baldegg institution in Switzerland: cooking, teaching, nursing, washing – only the language and climate constituted a problem.[111] Some sisters had only a couple of years to life and work in Tanganyika. Sr. Florina Rieder was trained as a nurse but fell ill herself after her first year at the mission. When she recovered, she continued her work as nurse but died within five years, becoming one of many who vindicated the idea of the personal ordeal in its most absolute sense.[112]

By then Sr. Florina had accomplished the salvation of many souls. Baptism in extremis was, it has been noted before, a central element of this missionary life, and many articles give examples of the sisters administering them.[113] Emergency baptisms were noted in the hospital statistics for Msimbazi.[114]

The missionary sister was a spiritual leader who aspired to 'social or spiritual motherhood'.[115] As a woman, the childless nun was a mother to the social body. The gendered roles in the bourgeois world and within Catholic society idealized mothers as hard-working, empathic caregivers in society. In the mission station, the nursing sister could play the role of sister and mother to many. The Virgin Mary and Martha[116] were the ideal role models:

> "To be a sister means to work with great love and a willingness to sacrifice, so that everyone will sense that it is a bride and sister of Jesus who is nursing them [...]. You must not look at your patients as though they were your actual siblings, but as brothers and sisters through Christ."[117]

Such work in the mission was hard. At one point in the early 1940s, Sr. Deotilla felt compelled to caution her fellow sisters in Switzerland in case they underestimated the degree of

[110] *Einiges aus der Mission*, in Providentia, 1927.
[111] *Aus den Missionsbriefen*, in Providentia, 1927.
[112] *Aus den Missionen. Sr. M. Florina Rieder, Missionsschwester*, in Providentia, 1931.
[113] I am grateful to Katharina Stornig who made me aware to the sustained presence of baptism *in extremis* even in later sources. Many times these stories were told In relation to the care for lepers and epileptics. Sr. M. Nikolata, *Aus den Missionen. Usamini*, in Providentia, 1934. In the 1950s work at the mission hospital in Ifakara was crowned by a series of baptisms. At this moment it is no longer clarified if these were conversions of patients who recovered after treatment. *Aus Missionsbriefen*, in Providentia, 1953.
[114] Sr. Innozentia M. Hürlimann, *Aus den Missionen. [Bericht über Msimbazi, Krankenstatistik]*, in Providentia, 1938. Sr. M. Lina, *Aus den Missionen*, in Providentia, 1941.
[115] The concept is a great theoretical tool for history: It helps to understand the gendered concepts of welfare: Rebecca Jo Plant et al., *Introduction: A new generation of scholars on Maternalism*, 2012, p. 4. It can also help to understand African history better, not least by showing motherhood as a social institution: Rhiannon Stephens, *History of African Motherhood*, 2013. Social motherhood is often also termed "geistige Mütterlichkeit" Christa Schnabl, *Gerecht sorgen*, 2005, pp. 34-37. This 'intellectual motherhood' was a concept that was also present in the colonial discourse in Germany: Katharina Walgenbach, *Weisse Frau*, 2005, 138-140. For the Catholic articulation in Switzerland, for which I think the term social is more adequate, see: Sonja Matter, *Katholizismus, Frauenbewegung und soziale Sicherheit*, in Schweizerische Zeitschrift für Religions- und Kulturgeschichte, 2011, p. 517.
[116] Martha was the sister of Lazarus and Mary Magdalene. Martha was one of the first converts of Jesus Christ and served him with hard domestic work. At the same time she successfully prayed for her sister Mary Magdalene to convert from a sinful lifestyle.
[117] Sr. M. Crescentia, *Für Stille Stunden*, in Providentia, 1930.

hardship in mission work, misled by the more enthusiastic reports of the missionary sisters.[118] The ways in which social motherhood was lived out in the African mission field was certainly different from the way it would be lived in Switzerland. Social motherhood in the mission, one can safely assume, had a different audience with diverse expectations of gendered behavior and hierarchies. A similar argument can be made for the history of nursing. For instance, nursing in the mission developed very differently from the way Fritschi described it for Switzerland. Whereas in Switzerland the power of the doctor over nursing was being firmly established at the turn of the century, doctors were often absent in the missions and the nurse practiced almost autonomously.

## The missionary as (touring) mission doctor

The Baldegg sisters (and their Benedictine precursors) played a central role in establishing both missionary activity and cosmopolitan medicine in Ulanga. But the first practitioners of mission medicine were the priests at the mission stations who delivered medical treatment both at the station and while out on tours. A number of photographs in the collection of the Swiss Capuchins in Olten testify to these practices in the mid 1920s.[119]

**"Missionary dispenses medicine to a child"[120]**

Medical practice by the missionary was very fluid. Not always, as the second picture suggests, were the patients aware of the kind of medical treatment they were given. It is not even obvious that the child in this picture is aware that it is receiving 'medical treatment' at

[118] Sr. M. Deotilla, *Aus den Missionen*, in Providentia, 1941.
[119] The "Missionsprokura der Schweizer Kapuziner" houses a collection of photographs used and still use for publications, as well as a collection of albums which were used – most likely – to present the mission to the sponsors, and maybe even to those who were recruited for mission work.
[120] Photograph from *Kipatimu: P. Wolfram gibt einem Kind Medizin*. PSKO.

all.[121] Drugs were limited both in terms of availability and of the range of application. They were also not strictly biomedical, as small presents like sugar were included and artefacts like small images of saints accompanied medicine. The priests had but a basic training in medicine. Being aware of his lack of training, P. Werner Huber made his way to the government hospital in Kilwa to undergo a short medical training course for two days. According to his account, the doctors allowed him to attend their consultations and treatments and explained to him whatever he showed an interest in learning about.[122] P. Werner was probably one of the priests who were more proficient in medicine than the others and he engaged quite intensively in medical practice, as we shall see when we look at the leprosy settlement in Kipatimu. One of his successors was P. Medard Baumgartner, who recounted his medical successes in 1934. He listed his training as a sanitary soldier in the Swiss army during the war as his credentials (keeping in mind that the Swiss army was not engaged in actual combat). P. Medard claimed that he "made all the injections himself against Leprosy, Yaws and Syphilis and it was never reported that he made any mistakes in the treatment of his people." He continued to explain that his mission station was "far off from any other government medical station, [...] it would be of great advantage if they could be treated at our Mission."[123]

## Mission Medical Institutions

### MSIMBAZI: THE 'HOSPITAL'

More specialized medical care was the domain of the Baldegg sisters and was provided in designated spaces, often dubbed 'dispensaries' or 'hospitals'. The first Baldegg sisters arrived in Dar es Salaam in June 1921. Soon, they took up visiting patients at the huge Sewa Hadji Hospital, where, according to their estimates, 800 to 1,000 African patients were nursed at the same time.[124] Not much later, they introduced medical mission work in a specialised institution belonging to the Mission. The mission station of Msimbazi used to be considered a rural place in the 1920s when the Baldegg missionary sisters started their social and medical work there. The logics of institutional succession in the path of the Benedictines and because Msimbazi was closest to Dar es Salaam explain why medical work by the Baldegg Sisters medical work took off in Msimbazi first. Consequently, the first report on mission medical work- it was the sixth report from the entire mission field - came from the “Negro-Hospital” in Msimbazi. Three tin houses

[121] Photograph from: *Kipatimu: P. Wolfram gibt einem Kind Medizin*. PSKO.
[122] *[photograph] Das Spital von Kilwa*. PSKO.
[123] TNA Acc.450/HE/178/16: P. Medard Baumgartner, *Letter to District Officer. R.C. Mission Mpanga, 06.09.1934*.The district administration did not criticize his capabilities, but noted that P. Medard should be informed that "all patients must be treated irrespective of their religion"TNA Acc.450/HE/178/16: Tanganyika Territory Assistant District Officer Kiberege, *Letter to Direct. of MS, Kwiro 28.09.1934*.
[124] *Departements-Verteilung bei unseren ehrwürdigen Missionsschwestern in Dar-es-Salam und Simbasi*, in Missionsbote. Missions-Nachrichten der Schweizerischen Kapuzinerprovinz, 1922. The German Benedictine sisters were reported to be in charge of the leprosarium at Sewa Hadji. Josef Schmidlin, *Die katholischen Missionen in den deutschen Schutzgebieten*, 1913, p. 120.

constituted this hospital, one each for males and females and the biggest one for war invalids who had already stayed for a long time at the hospital. Three thatched huts were occupied by individual patients, and one by a married couple. In 1922 all of these patients seem to have stayed in these huts for a long time already, and they seem to have considered the lodgings as their homes; and one of them, a patient with leprosy who had been abandoned by his family, requested the missionary sister to repair his house. Patients at the hospital received rations of maize and beans, which they used to cook their own meals. Drugs and dressings were dispensed by the missionary nurse in the mornings. On the particular Sunday visit that was reported in the *Missionsbote*, the patients also received fruits and cigarettes.[125]

In the mornings the nurse, at this time Sr. Innozentia, treated the patients for their various ailments. Out-patients arrived at the hospital from far and near, and the sister spent more of her time on the out-patients, pulling teeth and performing other routine tasks, than on the in-patients.[126] The patients were not all 'Africans'. According to the *Missionsbote*, there were Indians, Arabs, (Portuguese) Goans and others who came to see the *bibi ya dawa*, the honoured aunt of the medicines, or the *bibi mganga*, the honoured healer aunt.[127]

It is difficult to reconstruct how an African person in the 1920s would understand the healing power of the missionary *bibi*. Missionary reports give examples of patients sticking out their tongues when they came with a problem with their eyes, because they were expecting that the missionary would always diagnose the evil forces at work by looking at the tongue of the patient.[128] It seems quite clear from this example that hearsay was a major source of knowledge about the medicine of the missionary sisters and it is well established fact that curiosity was an important reason for trying the missionary dispensary.[129]

In 1930, Sister Adelina reported to her Baldegg sisters in the Journal *Providentia* about her work:

> "Between 9 and 12 in the morning, about 150 patients come to see me at the dispensary. One of the bigger girls assists me. I start with pulling teeth, a task I like to execute. I have pulled more than one thousand already. We group patients with similar grievances in order to advance quicker [...] Often they have wounds terrible enough to make one glance at the Saviour before one can take care of them [...]. All patients are very confident in the mission sister and they resist going to the hospital in Dar es Salaam [Sewa Hadji], since there are no sisters there. In case I have to explain them that I cannot help with their problem, they reply, I should try my best, even if they have to die. If only we had a hospital, it would be filled to the brink and beyond and we could certainly win countless) souls for [the kingdom of] heaven. I have been able to baptize many very sick children." [130]

[125] *Das Negerhospital in Simbasi*, in Missionsbote. Missions-Nachrichten der Schweizerischen Kapuzinerprovinz, 1922.
[126] *Departements-Verteilung bei unseren ehrwürdigen Missionsschwestern in Dar-es-Salam und Simbasi*, in Missionsbote. Missions-Nachrichten der Schweizerischen Kapuzinerprovinz, 1922.
[127] *Krankheit und Krankenpflege in unseren Missionen*, in Missionsbote der Schweizer Kapuziner in Afrika, 1924.
[128] P. A., *Bilder aus dem Missionsleben*, in Missionsbote. Missions-Nachrichten der Schweizerischen Kapuzinerprovinz, 1923.
[129] There is an extensive literature highlighting African inquisitiveness and anxieties about missionary/European medicine, e.g. Nancy Rose Hunt, *Colonial Lexicon*, 1999; Luise White, *Speaking With Vampires*, 2000; Markku Hokkanen, *Quests for Health*, in Journal of Southern African Studies, 2007; Walima T. Kalusa, *Language, Medical Auxiliaries*, in Journal of Eastern African Studies, 2007.
[130] Schwester M. Adelina *Aus den Missionen. Sr. M. Adelina erzählt von den lieben Heidenkindern*, in Providentia, 1930.

Clearly, we see that the tin-house 'hospital' was not a comprehensive enough health service in the perception of the missionary sister. Her account reads as if she felt incompetent in matters medical, hindered by a lack of both training and resources, in the face of the suffering and the expectations of the patients coming to see her. But she also wanted a hospital for other practical reasons that had to do with the mission.

The definition of a hospital was indistinct or flexible at the time. In mission statistics, dispensaries like the one described here, would qualify as a *hospital* if they offered beds for in-patients.[131] Here the sister realized that her services did not constitute a modern hospital, which would have to provide diagnostics that went beyond the most obvious common diseases and surgical services surmounting pulling teeth and applying stitches in case of accidents. Sister Adelina's wish to create a hospital was not purely medical, however. In 1944, when mission hospitals had become more medico-technical, a Capuchin wrote that a mission hospital's duty was not only to "make people healthy. [...But] surely it is a reward and a success, when a human being is well prepared for the great journey and the hour of death."[132] In Sister Adelinas' view the task of the hospital in the mission was to serve as a place "to win countless souls". Hospital or not - healing in those days was a rather tough affair: it seems to have rested on hard, unquestioning work on the worldly side and the hope for the end of terminal sickness and redemption from pain and sin after death. P. Guido noted:

> "On April 11 many of the Africans are sick in this misty, wet season of rain, especially children. Joyfully I rush to see them full of hope that they will die soon. Since, honestly speaking, when I see the misery and the sinful lives of these Africans, I am thankful to God, lest he fetches a small angel from this or another hut, before they become black inside their souls as well. Every funeral of a child is a day of joy to me."[133]

Baptism *in extremis* was a path to heaven for the former 'heathen', which was both redemptive for the African and a legitimate, quantifiable success of mission. About the successes of a sister in Kwiro, Sofi and Msimbazi, the Mission reported in 1931: "She wrested even Muslim souls from the devil".[134] Compared to the complicated process of testing the faith of the resilient mind of a healthy person for years, 'emergency' baptism was a way to win souls without years of preparation. It allowed missionary sisters at the dispensary to share in the dispensing not only of medicine but also of sacraments, which were otherwise the preserve of priests. Reports by sisters from this time are few but there is hardly one that does not mention emergency baptism stories and numbers.[135] In this spiritual worldview true redemption for the human being did not

[131] This definition clearest in: *Die Mission des apost. Vikariates Dar-es-Salaam in Zahlen. Missionsstatistik des Jahres 1928.*, in Missionsbote der Schweizer Kapuziner in Afrika, 1929.
[132] Pater Leodegar, *Heilet die Kranken!*, in Missionsärztliche Caritas, 1942, p. 22.
[133] P. Guido Käppeli, *Mein Hochwürdiger P. Provinzial. Kwiro, 21.05.1922*, in Missionsbote. Missions-Nachrichten der Schweizerischen Kapuzinerprovinz, 1922.
[134] *Aus den Missionen. Sr. M. Florina Rieder, Missionsschwester*, in Providentia, 1931.
[135] For example, see excerpts from the Letter of Sr. Innozentia: P. Medard Baumgartner, *Aus der afrikanischen Diaspora*, in Jahresbericht der Schweizer Kapuziner in Afrika 1931/1932, 1932. Sr. M. Nikolata, *Aus den Missionen. Usamini*, in Providentia, 1934; Sr. M. Eucharis, *Aus den Missionen.Msimbasi-Brief von lieb Sr. Eucharis*, in Providentia, 1931.

only lie with the sick person whose body was being attended to and sent on its "great journey" – it also came to the person giving care.

## The (nursing) home and asylum – a missionary strategy

Building communities through boarding schools and Christian villages had been a missionary strategy from early on.[136] The concept of an immobilized patient in an 'asylum'-setting had a number of advantages over the transient itinerant system of proselytizing. There are a number of reasons why medical work was a good field of activity for the mission, for example in Kwiro – and much of it was related to the institutional setting it produced. We have seen the situation at Msimbazi 'Negro-Hospital', and we encounter it in the leprosy work done by the Mission, and will meet it again, when we look at the maternity in Ifakara. In a volume celebrating the 400-year jubilee of the Capuchin Order the strategy became quite explicit. The book told the readers, that the African mission used "schools and the practice of Caritas" as major instruments. This statement was followed by a statistic which gave the numbers of "sick persons entrusted into our care" as a sure sign of progress.[137]

The tradition of Christian charitable work was one of the creation of hospices. Hospitals were places for the poor, where Christ's work was sought to be re-enacted as an exercise in care.[138] The hospital in the colony often was an amalgam of medical and charitable work.[139] The hospital in the 20th century had developed into a technical spectacle, a trend that we shall see proven by Capuchin medical services.[140] But the 'hospitals' of the Baldegg sisters did not exclusively develop along the technical care path. They are good example for the ways in which the poor relief hospice was modernised in the colonial situation into a place where racial divide and love, difference and bodily touch were amalgamated.[141] In the course of the 19th and early 20th century, the Catholic Church developed a large array of partly specialized modern institutions that drew upon the hospice tradition and meant to 'teach' those in their charge by 'guidance' and love. It included institutions like kindergartens, boarding schools, workshops for poor or disabled people, homes for people with chronic diseases, for children who were orphaned or in need of some sort of 'correctional measure'. Recent research on the history of Catholic care and teaching institutions has uncovered the history of harshness and sometimes

[136] Siegfried Hertlein, *Wege christlicher Verkündigung*, 1983, Vol. II, pp. 85-94; Justin Willis, *Nature of a Mission Community*, in Past and Present, 1993.
[137] Magnus Künzle, ed. *Die schweizerische Kapuzinerprovinz. Ihr Werden und Wirken, Festschrift zur vierten Jahrhundertfeier des Kapuzinerordens*, 1928; P. Otto Hophan, *Die ausländischen Missionen*, 1928, pp. 297-298.
[138] Hubert Koling, *Sorge für die Kranken*, 2007; Clemens Brentano, *Die Barmherzigen Schwestern in Bezug auf Armen- und Krankenpflege*, 1912. Lukas Burkart, *Poverty*, 2002; Guenter B. Risse, *Mending Bodies*, 1999, pp. 148-165; Gisela Drossbach, *Hospitäler*, 2007; Christina Vanja, *Heilanstalten*, 2007; John Henderson et al., *Introduction: the World of Hospitals*, 2007.
[139] Mark Harrison, *From Western Medicine to Global Medicine - Introduction*, 2009, pp. 4-5.
[140] Joel D. Howell, *Hospitals*, 2003.
[141] John L. Comaroff et al., *Revelation and Revolution II*, 1997, chapter 7.

brutality in these institutions.[142] Aberrations were not just individual lapses, they must be read – at least in part – as a result from the way these institutions conceptualized social relations and hierarchies. That history cannot be told here. Missionary discourse presented these institutions as places of refuge – and the institutions certainly have this quality in the eyes of many Africans.[143]

The background to the missionary strategy of establishing settled communities was that the Mission had encountered a series of obstacles. Analytical papers on 'the problems of mission' were numerous at that time. Polygamy and women being regarded as commodities by men, the presence of Islam, superstition, and the lack of persistence of affiliation with the mission were the central themes.[144] These issues must have been central at this time, when the rather inexperienced mission had to find strategies and ways to ensure their progress.

Leprosy work in particular fitted traditional Catholic conceptualizations of ill-health and healing.[145] Leprosy work also suited the aims of the mission well. Many scholars have written great works on leprosy, a disease that captured the humane imagination because it presented widespread suffering and was also an ideal platform on which the poor-relief hospital could be turned into a colonial missionary medical institution.[146] These studies all hinge on the issue of welfare work, research, medicalization and bio-power. Many of the central arguments for missionary leprosy work therefore have been made already. Megan Vaughan, for example, has pointed to the idea to graft 'village identities' onto the inmates.[147] But it is still important to speak about the leprosy work of the Capuchin mission in the leper villages because it was fundamental to the history of missionary health care in Ulanga. One of these villages was Tabora, half an hour by foot down the hill from Kwiro.

### *Tabora*

Tabora Leprosy Camp was a 'modern' village. It was comparatively densely populated, was accessible by road and possessed a brick communal house as well as a chapel. It was a substantial settlement in terms of the number of its inhabitants, the fertility of its soil and the size of the ground it covered: roughly 6.5 square kms. In terms of its administrative set-up, the village differed strongly from the majority of other places. It had an African village headman, a *Jumbe*, but it was here, too, that the state was present in its most modern forms.

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[142] Peter Schallberger et al., *Hilfe für die Schwachen aus dem Geist des Göttlichen? Die Bedeutung von Religion bei der Professonalisierung der Sozialen Arbeit...[Zusammenfassung der Forschungsbefunde]*, 2010; Urs Hafner, *Heimkinder*, 2011.
[143] Sr. M. Valentina, *Das Heim für die Epileptischen bei der Missionstation Kwiro*, in Missionsbote der Schweizer Kapuziner in Afrika, 1935/6.
[144] *Unsere Mission in Ifakara*, in Missionsbote der Schweizer Kapuziner in Afrika, 1924.
[145] Marcel Dreier, *Wer möchte da nicht krank sein*, 2011.
[146] Cf. John Iliffe, *African Poor*, 1987, chapter 12. Megan Vaughan, *Curing Their Ills*, 1991. Eric Silla, *People Are Not The Same*, 1998. and Michael Worboys, *Colonial World as Mission and Mandate*, in Osiris, 2nd Series, 2001. In the last decade: Shobana Shankar, *Social dimension*, 2006; John Manton, *Administering Leprosy Control*, 2006; Rod Edmond, *Leprosy and Empire*, 2006. Kathleen Vongsathorn, *First and Foremost the Evangelist*, in Journal of Eastern African Studies, 2012.There are a couple of works on leprosy care with a particular focus on Tanzania, for example: Knud Balslev, *History of Leprosy in Tanzania*, 1989; Susanne Harlfinger, *Geschichte der Lepraarbeit*, 2012.
[147] For an non-Africa study see also: Michelle Therese Moran, *Colonizing Leprosy*, 2007.

Historical descriptions of this place oscillate between moments when Tabora was seen as a place of outright desperation and moments filled with hopeful redemption. But for much of its existence Tabora never lost its commonalities with daily life in any another village in Ulanga. There never was a fence around the camp, and many of the inhabitants of Tabora village did not suffer from leprosy. A missionary sister related the story of visitors in the 1930s who, after having walked in Tabora for a while, asked "But where is the famous leprosy village?"[148]

Tabora had started under the German colonial administration in the course of the establishment of a leprosy control system based on a rather centralized approach. Tabora was an example of this effort at centralization, based on the idea of one camp for one district, each just a couple of miles from the centre of military administration – in this case Mahenge.[149] The camp was to be delimited and separated from the road going to Ifakara by a cordon sanitaire, confined on another side by the sharp descent towards the Kilombero plain, and extensions of the steep Mahenge mountain landscape.[150] The missionaries later claimed that the camp had been initiated in May 1909 by the Benedictine mission rather than by the government, but they had to wait for new staff at the Boma before they received support for their plans.[151] Lorne Larson has argued that the Benedictine mission had been highly interested in doing leprosy work because there was enough work to justify that a community of sisters was set-up on a mission station – a necessary condition to work with nuns on missions at all.[152] In October 1909 the camp was inaugurated, after the Jumbes of the nearest lying villages had been pushed to build huts for the lepers they sent to the camp. 326 settlers were sent to Tabora at first. Their numbers rose quickly, and by 1912 approached 800 inhabitants in two settlements.[153]

From the beginning, the camp was run by Government and mission in collaboration. At first, medical administration was superimposed on political administration and the doctor of the German Mahenge military post was in charge of all administrative questions, including law and order: "The real *Bwana Shauri* [head of the local colonial administration] at Tabora was the doctor of the Mahenge post. Every Thursday he visited the settlement, settled *Baraza* business [public announcements by the colonial administration and arbitration of disputes, "on the porch"], dealt out punishments, and ordered the return of runaways."[154] There was no cure but only care at this time. The care was in the hands of the mission sisters who, together with

[148] Sr. M. Valentina, *Das Heim für die Epileptischen bei der Missionstation Kwiro*, in Missionsbote der Schweizer Kapuziner in Afrika, 1935/6, p. 185.
[149] Otto Peiper, *Bekämpfung der Lepra*, in Beihefte z. Arch. f. Schiffs und Tropenhygiene, 1913. Wolfgang U. Eckart, *Medizin und Kolonialimperialismus*, 1997, pp. 319-326.
[150] Otto Peiper, *Bekämpfung der Lepra*, in Beihefte z. Arch. f. Schiffs und Tropenhygiene, 1913.
[151] TNA District Book, District Office Mahenge, No.1 / Medical: Pater Jesuald Loretz et al., *Tabora Leper Settlement*.
[152] Lorne Larson, personal communication, Ilkley 2010. Beatrix Biesel, *Tätigkeit der Missionsschwestern in Kwiro*, in Missionsblätter. Monatschrift der Benediktiner-Kongregation von St. Ottilien und ihre Missionsvereins, 1917.
[153] The two villages probably were administrative units seen from above. Settlement I would assume was dispersed, probably configured on family (Peiper would speak of tribal) ties. Otto Peiper, *Bekämpfung der Lepra*, in Beihefte z. Arch. f. Schiffs und Tropenhygiene, 1913. Eckart says that there were 4 villages: Wolfgang U. Eckart, *Medizin und Kolonialimperialismus*, 1997, p. 334.
[154] TNA District Book, District Office Mahenge, No.1 / Medical: Pater Jesuald Loretz et al., *Tabora Leper Settlement*.

African staff, dressed the sores and took charge of those fully unfit to sustain their livelihoods. At some point, two Benedictine sisters seem to have lived in the Tabora itself.[155]

After the Benedictines had been forced to leave Kwiro, we can assume that the camp was medically and spiritually in the hands of the African staff who had worked with the mission. Leprosy work was re-established soon after the war. From 1920 until 1921 White Fathers were called in to take charge of the leper camp.[156] The British took stock of the leprosy cases in the district[157], and stopped the enforced settlement of lepers into isolated camps.[158]

The first impression the Capuchins had of Tabora was rather bleak: coming to the camp to observe Mass for the first time on 27 October 1921, Father Guido Käppeli found a church, that had been built with a gift from Pope Pius X of 1,000 Swiss Francs[159], and some other stone buildings. The school however was but a shabby hut made of thatch. During the service, Father Guido was almost sick from the stench of the wounds, but felt at least that the prayers "rose towards the sky like frankincense." He noticed that some "God-pleasing work could be done there, especially by sisters".[160] Käppeli himself engaged in caring for the lepers as so many pious people had done before him, and he took a hoe to work on the road to Tabora in May 1922 – leaving the teachers there in awe and the women cheering and singing for him.[161]

Roughly a year had passed from P. Guido's first Mass, when Sr. Innozentia started her new office "down in Tabora" and she too was rather appalled by the smell of those she had to take custody of. Sections she wrote in diary style gave a first-hand impression of the tasks at Tabora:

> "September 1, the writer took her new office down at Tabora. As long we do not have more sisters here, I cannot devote more than Mondays and Fridays to these poor. The English doctor of Mahenge [162] [...] taught me the different stages of the disease. There is apparently no other help that can be given beyond cleaning their sores and dressing them with clean cloths every day. Soon the doctor took off and I was alone with all sick people and with the two helpers I was given. I had a close look at my fosterlings. With joyful whoops the Christians quickly came to greet me: "I am a Christian, my name is Ubald, [...]". And now I had the opportunity to look at an image of misery the like I had never seen in my life. Oh, these terribly deformed faces! [...] Many young men, in the first stage of leprosy, sat closely together, laughing and happy [...] but then begging started and I had not expected anything

[155] P. Guido Käppeli, *In Tabora bei den Aussätzigen [Letter Kwiro, 25.01.1922]*, in Missionsbote der Schweizer Kapuziner in Afrika, 1922.
[156] TNA District Book, District Office Mahenge, No.1 / Medical: Pater Jesuald Loretz et al., *Tabora Leper Settlement*.
[157] TNA 450/34/3 District Office Mahenge, *Letter to Principal MO. Mahenge 07.10.1920*.
[158] TNA District Book, District Office Mahenge, No.1 / Medical: Pater Jesuald Loretz et al., *Tabora Leper Settlement*.
[159] Photograph from *Tabora: Aussätzigendorf,* 1922? PSKO.
[160] P. Guido Käppeli, *In Tabora bei den Aussätzigen [Letter Kwiro, 25.01.1922]*, in Missionsbote der Schweizer Kapuziner in Afrika, 1922. This clearly reverberates with the work done by the Benedictine Sisters. Beatrix Biesel, *Tätigkeit der Missionsschwestern in Kwiro*, in Missionsblätter. Monatschrift der Benediktiner-Kongregation von St. Ottilien und ihre Missionsvereins, 1917; Bernita Walter, *Von den Tutzinger Schwestern zu den Baldegger Schwestern*, 1997; Schwester Erika Lischer, *50 Jahre Baldeggerschwestern in Tansania 1921-1971 (manuscript)*, (PADSM/Institut Baldegg, 1971). Lischer cites Sr. Beatrix who described the work with lepers as the "best opportunity for health care work" at the time. Schwester Erika Lischer, *50 Jahre Baldeggerschwestern in Tansania 1921-1971 (manuscript)*, (PADSM/Institut Baldegg, 1971), p. 41-43.
[161] P. Guido Käppeli, *Mein Hochwürdiger P. Provinzial. Kwiro, 08.06.1922*, in Missionsbote. Missions-Nachrichten der Schweizerischen Kapuzinerprovinz, 1922.
[162] In a second edition of her report, the name of the doctor is given as Dr. Tetschborn [?]. The post of medical doctor at Mahenge was often not filled, and often by Indian doctors. Sr. Innozentia M. Hürlimann, *Ein Licht in der Finsternis*, in Missionsbote der Schweizer Kapuziner in Afrika, 1960, p. 138.

> else, all being dressed in a most scanty manner.[...] 'Mama, a piece of cloth, a blanket [...] a little salt?' The two black assistants cleaned the sores, applied iodoform and dressed them. At noon we had finished and even the ugly smell had vanished a little [...and] I proceeded to visit the school for lepers, counting only 35 children today, and they were in the middle of reciting the catechism."[163] [164]

From 1926 there is a series of photographs that supports the image presented by Sr. Innozentia. They show how clothes were given, and food distributed. This regime, one of poor-relief more than medicine, was in place in Tabora for most of the 1920s, and probably did not differ much from the earlier regime in German Benedictine times.

### *Assisi near Kipatimu: a new foundation and cooperation with government*

Kipatimu was another important centre for the Capuchin mission. Located in the coastal hinterland closer to Kilwa than Dar es Salaam, and increasingly disconnected from Ulanga, Kipatimu was the only mission station of the Capuchins in a large, but peripheral area.[165] The Benedictines had already engaged in medical work at this station.[166]. Reaching Kipatimu required a long journey from Dar es Salaam to Kilwa on a dhow and then a trek overland to Kipatimu. The station was opened in 1923 with no sisters in attendance. Nonetheless the Mission started to do leprosy work there, knowing that sisters would soon be needed.

In 1927 Maranta and P. Werner attended a conference of the Colonial medical services on the treatment of leprosy. The specialist from the British Empire Leprosy Relief Association who was invited as the expert at the conference gave a clear signal to the missions: because of their continuous work and long-term staffing, the mission was the only body capable of undertaking the fight against leprosy. As a result, the missionaries concluded that government and BELRA would cover the costs incurred by the missions for their leprosy work.[167] In addition, the parish priest probably expected that successful leprosy work would eventually lead to the quicker despatch of sisters to work at Kipatimu.[168] This would then also raise considerably the importance of the Kipatimu mission. The plan did not immediately work out. No sisters came to Kipatimu before 1929.[169] Also government support paid for only a fraction of the cost of the

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[163] Sr. Innozentia M. Hürlimann, *In Kwiro*, in Gruss aus Baldegg, 1923. See also: *Schwesternberichte aus den Missionen. In Kwiro [Sr.N.N.]*, in Missionsbote der Schweizer Kapuziner in Afrika, 1923; *Schwesternberichte aus den Missionen - In Kwiro [Sr. Innozentia]*, in Missionsbote der Schweizer Kapuziner in Afrika, 1923.

[164] *Schwesternberichte aus den Missionen - In Kwiro [Sr. Innozentia]*, in Missionsbote der Schweizer Kapuziner in Afrika, 1923; *Schwesternberichte aus den Missionen. In Kwiro [Sr.N.N.]*, in Missionsbote der Schweizer Kapuziner in Afrika, 1923; Sr. Innozentia M. Hürlimann, *In Kwiro*, in Gruss aus Baldegg, 1923.

[165] PADSM box 144: Daniel Rothenfluh, *Matumbiland, Matumbi Leut'. Ein Missionsbild*.

[166] Amandus Heinze, *Krankheiten und Krankenpflege in Kipatimu*, in Missionsblätter. Monatschrift der Benediktiner-Kongregation von St. Ottilien und ihre Missionsvereins, 1912/13.

[167] DAK folder "Archbishop DSM Yan 61-Mei 65" [misplaced document in this folder?]: P. Werner *Bericht über die Aussätzigenkonferenz in Daressalaam am Osterdienstag, 19.04.1927*.

[168] *Einzug der Schwestern in Kipatimu*, in Missionsbote der Schweizer Kapuziner in Afrika, 1930. P. Fridolin Fischli, *Assisi bei Kipatimu*, in Missionsbote der Schweizer Kapuziner in Afrika, 1931.

[169] Then they left again in 1933; and returned in 1936. Institutsarchiv Baldegg B IV 11,1: *[file] 1915-1934 Pflegerinnenschule Baldegg: Korrespondenz und Akten etc* When sisters were absent much of care work for leprous patients was most likely done by African staff.

settlement.[170] But Kipatimu always had a special position in the set-up of medical services by the Capuchin mission. It was to have a dispensary with a significant number of beds and the building of a full-scale mission hospital there was considered. For some time in the late 1930s and early 1940s, Bishop Edgar Maranta posted a mission doctor there.[171]

What is important in the example of Kipatimu in the context of this thesis is to learn how promising institutions were likely to be 'copied'. Frederick Cooper has argued that such copying processes are typical for development practices and he has termed them 'template mechanisms'.[172] Kipatimu shows how complex this mechanism is. At first glance, it is only logical that a successful model would be re-enacted. But one cannot copy 'success'. What are copied are the factors and elements which promise success, based on the analysis and knowledge of the 'model'. Although Tabora was based on institutional concepts typical to the Catholic movement Europe, it was an institution that could not be copied from Switzerland. The relations to the African society in which the institution was placed, to the colonial government and the imperial humanitarian leprosy organisation BELRA, and the medical work implied by leprosy care, were all new to the Swiss missionaries, but they were major reasons for copying the template.[173] We know for sure that the 'founding father' of leprosy care in Kipatimu, P. Wolfram Meyer, had experience of leprosy work at Tabora, and he believed leprosy work to be helpful in missionary work.[174] Transferred to Kipatimu, he found himself in a situation where he needed to establish a settled community in a strong Muslim environment. His successor, P. Werner Huber[175], actively sought to cooperate with the local colonial government.

Two and a half hours from Kipatimu the German colonial government had started a leprosy village at the end of the first decade of the 20th century.[176] Like Tabora from Kwiro, the leprosy village was about half an hour's walking distance from a government post in Kibata, a substation to Kilwa, the important centre on the coast. The Germans had held that the leprosy village in Kibata was in an attractive location, with fertile soil.[177] In July 1925 P. Wolfram visited the camp at Kibata during a trip to Kilwa. He met with the *Jumbe* of the camp and told him of the work the Mission did in the Tabora camp at Kwiro – that there were schools, a Church and that

[170] The Mission claimed that Government only carried 1/7 of the cost in 1929. Medard Baumgartner, *Die Aussätzigensiedlung Assisi*, in Seraphisches Weltapostolat des Hl. Franz v. Assisi, 1929.
[171] Dr. Adelheid Schuster arrived in December 1938. PAL 1061.4: Adelheid Schuster, *Letter to P. Odo.(OSB). Kipatimu 04.02.1939*. See also chapter 6.
[172] Frederick Cooper et al., *International Development - Introduction*, 1997, p. 24. Kipatimu was always planned to become a centre for Capuchin mission medical work, but there were no doctors posted there for an extended period.
[173] For a history of leprosy care in Switzerland at the turn of the 20th century see: Christian Müller et al., *Lepra in der Schweiz*, 2007, pp. 193-199.
[174] P. Wolfram Meyer, *Assisi in Afrika*, in Die Familie. Beilage zum Willisauer-Bote, 1927. It was also reported that the Mission succeeded in convincing leprosy patients to join the settlement at its beginning, when a ex-soldier who had seen the settlement in Tabora supported the accounts by the missionaries: P. Wolfram Meyer, *Wie die Aussätzigensiedlung 'Assisi' zustande kam*, in Seraphisches Weltapostolat des Hl. Franz v. Assisi, 1933.
[175] He spent just over 4 years in Kipatimu before he died there in February 1928.
[176] Otto Peiper, *Bekämpfung der Lepra*, in Beihefte z. Arch. f. Schiffs und Tropenhygiene, 1913.
[177] The missionaries agreed to this view: *Kipatimu [Leper camp],* 1926.

"sisters would come every week to visit and to care for the sick."[178] The mission built a bush school in the camp. The mission had now clearly been sent on a trajectory that would turn it into a copy of Tabora. But soon it was found that the place was too far to be serviced from the Mission at Kipatimu. Negotiations with the Government and with the inhabitants started with the aim that the settlement could be moved closer to the mission station.[179]

**"The Bwana Shauri visits the lepers"[180]**

This photo was taken by the Missionary P. Werner when he took the new British administrator and his wife to the camp near Kibata. P. Werner commented: "They had never been there before. One day I invited them to see the whole misery. You don't see any seriously sick person in this image." The picture shows, apart from the *Bwana Shauri* and his wife, his assistant, the secretary of the colonial officer, the *karani* (probably second from right), and the hospital dresser (probably first from right) who came to dress the wounds of the patients once or sometimes twice a week. The man dressed in black in the centre of the picture probably is the *Jumbe*, himself afflicted with leprosy.[181]

The *Bwana Shauri* quickly granted the Mission the right to move the settlement. After consultation with local informants, a new place was found about half an hour from the Kipatimu

[178] His account to the Jumbe was supported by a former African soldier. P. Wolfram Meyer, *Assisi in Afrika*, in Missionsbote der Schweizer Kapuziner in Afrika, 1927.
[179] *Kipatimu [Leper camp],* 1926. P. Wolfram Meyer, *Assisi in Afrika*, in Missionsbote der Schweizer Kapuziner in Afrika, 1927. P. Wolfram Meyer, *Assisi in Afrika*, in Die Familie. Beilage zum Willisauer-Bote, 1927.
[180] Photograph from *Kipatimu [Bwana Shauri zu Besuch bei den Aussätzigen]*. PSKO.
[181] Photograph from *Kipatimu [Bwana Shauri zu Besuch bei den Aussätzigen]*. PSKO.

station. On 13 April 1926, he visited the new site and gave orders to clear the forest and bush. Eighty workers, recruited with the local Jumbes, did the clearing and built 12 huts with two apartments each. Only then did the inhabitants from Kibata come to check the place and subsequently returned to Kibata where they decided to move away and to the new site. The new 'modern' huts, however, were not popular with the old inhabitants of the camp near Kibata. They would have preferred to build their own houses at places of their own choice. In response 23 'new' lepers were collected upon orders of the government from the local *Jumbes* to live in these huts. P. Werner gave out pieces of land as *shamba* (farms) and he could soon expect what he called the "exodus ex Aegypto into the land Assisi" to take place in July or August 1927. [182] The new camp was called "Assisi" and in 1929 Baldegg sisters were sent to support the Kipatimu mission in caring for the sick in general and those at the leprosy camp Assisi in particular.

In matters of leprosy, the government offered its full support in political terms and in the procurement of drugs while the Mission took responsibility for the care work. In 1930 the government and BELRA gave £50 for new buildings at Assisi.[183] The dressings were provided by both the colonial government's Medical Department and maybe also by mission donations received from Switzerland.[184] There are no numbers available that allow for a clear picture of the origins and contents of the donations.[185] For 1931 we know that the annual government contribution to the Mission for the support of lepers in Assisi equalled CHF 1,100 plus an extra CHF 750 in that year because of a famine. This was quite a substantial sum. Notwithstanding these contributions, the Mission lamented that New Assisi remained a huge financial burden for them.[186] And then, a mere couple of weeks later in February 1928, P. Werner died in Kipatimu. His successor would later write that he was faced with complaints by the inmates of the leprosy village as he did not having the same quality of networks to raise donations as P. Werner had had.

### *Tabora II: The era of a Wonderdrug*

At the time when Assisi was started, leprosy work in Tabora changed fundamentally. The camp near Kwiro took a new direction in January 1928 when treatment with injections of Hydnocreol was introduced.[187] At that very time, Alepol had just been marketed by Burroughs Wellcome as a new preparation of the oil from so-called Chaulmoogra (*hydnocarpus wightiana)*

[182] P. Wolfram Meyer, *Assisi in Afrika*, in Missionsbote der Schweizer Kapuziner in Afrika, 1927. The name was given in memory of Francis of Assisi at the occasion of his death exactly 700 years earlier. P. Wolfram Meyer, *Assisi in Afrika*, in Missionsbote der Schweizer Kapuziner in Afrika, 1927. P. Wolfram Meyer, *Assisi in Afrika*, in Die Familie. Beilage zum Willisauer-Bote, 1927.
[183] Tanganyika Territory, *Annual Medical and Sanitary Report for the year ending 31.12.1930*, 1930, p. 7.
[184] From Appenzell in particular according to one source:P. Medard Baumgartner, *Etwas vom afrikanischen 'Assisi'*, in Missionsbote der Schweizer Kapuziner in Afrika, 1929.
[185] On missionary collecting practices: Marita Haller-Dirr, *Unternehmen Mission, Teil 1*, in Helvetia Franciscana, 1999; Marita Haller-Dirr, *Unternehmen Mission, Teil 2*, in Helvetia Franciscana, 2000; Marita Haller-Dirr, *Unternehmen Mission, Teil 3*, in Helvetia Franciscana, 2000.
[186] P. Fridolin Fischli, *Assisi bei Kipatimu*, in Missionsbote der Schweizer Kapuziner in Afrika, 1931.
[187] A German sanitary sergeant there had done a short-lived and unsupervised medical trial on 4 patients with an injectable drug in 1912 Wolfgang U. Eckart, *Medizin und Kolonialimperialismus*, 1997, p. 339.

plant seeds and which was injected with much less blocking of veins and less pain than previous preparations.[188] It is not possible here to explain why Hydnocreol, produced in India and much thicker in viscosity than the British Alepol, was used in Ulanga.[189] Price and networks of logistics might have been a factor, or even the fact that the arrival of Alepol meant that government stocks of Hydnocerol were now available for Ulanga.[190]

The Government Medical Officer in Mahenge appears to have supported leprosy work at Tabora, and it might have been on his personal initiative that the drug arrived in Ulanga.[191] Certainly it was the GMO who trained the sister in charge, Sr. Innozentia, to give the injections, and he went on supervising the work – weekly – at Tabora [192] The oil being viscous, injecting it into arms and legs was painful, and sometimes resulted in fevers, and often in distress to children. To the sister, this work was tiresome, and it took a whole morning to give 100, some reports say up to 200 injections, on her visit to the sick at Tabora. "Caritas Christi urget nos", wrote P. Wolfram on the motivation needed to go down to Tabora twice weekly[193], but there were also another, more secular und immediate reason for the injections: This treatment appeared to be a major success. The sister reported on three complete cures within the first year of treatment. And the MO also confirmed "that treatment is popular is shown by the [attendance] figures especially when it is taken into consideration that in no case has treatment been pressed on the people."[194] The District Officer also noticed the change: "Since 1922, when she found the lepers somewhat difficult to manage and control, until January 1928, the work of the Sister Superior [Innozentia] was confined to organisation, dressing sores and such attentions as are generally paid to incurables..." Now the sick would come forward voluntarily and seek treatment. At this time, in December 1928, the District Officer also knew of one complete recovery: the healing of a man called Placidus was in the words of the administrative officer a "wonderful advertisement" for the virtues of Hydnocerol".[195]

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[188] According to the British pharmaceutical codex " Hydnocreol-preparation consisting of the ethyl esters of the fatty acids of hydno-carpus oil with 4 per cent, of creosote" was producecd by Smith in Stansitreet Calcutta: (*http://www.new1.dli.ernet.in/data1/upload/0031/007/RTF/00001664.rtf* last accessed 24.01.2014). Chaulmoogra oil originated, was used and produced for the East African market in the Indian subcontinent. For an extensive discussion of 'chaulmoogra' see John Iliffe, *African Poor*, 1987, pp. 219-221.

[189] On Alepol, developed in 1927, and used in Tabora from probably about 1934: F. G. Rose, *A New Method Of Treatment Of Leprotic Infection Of The Nasal Mucosa*, in The British Medical Journal, 1929; Leonard Rogers, *Recent Advances In The Treatment And Prophylaxis Of Leprosy*, in The British Medical Journal, 1929; Alice Simpkin, *"The Treatment of Leprosy", by Miss Alice Simpkin, S.R.N., F.B.C.N.* , in British Journal of Nursing, 1927. TNA 61/129G folio 38ff: *Report [by SAS Mahenge] on Inspection of Medical Out-Stations. Mahenge and Kiberege Districts [07.01.1934]*; TNA Acc.450/HE/178/16: Tanganyika Territory Director of Medical Services, *Letter to Fr. Gerard Fässler. DSM 12.10.1937*.

[190] It is also possible that Hydnocreol was developed at the same time as Alepol, even using some of the same composition.

[191] TNA 450/34/3 DO Mahenge, *Letter of District Officer to Dir of Med. Serv. Mahenge 20.12.1928*.

[192] TNA 450/34/3 *Letter from Medical Office, Mahenge to Dir of Med. Services. 06.04.1928*.

[193] Wolfram Meyer, *Poesie und Prosa des Missionslebens [Auszüge aus seinem Tagebuch]*, in Providentia, 1929.

[194] TNA 450/34/3 *Letter from Medical Office, Mahenge to Dir of Med. Services. 06.04.1928*.

[195] TNA 450/34/3 DO Mahenge, *Letter of District Officer to Dir of Med. Serv. Mahenge 20.12.1928*.


**Tabora: "Sr. Innozentia und Sr. Valentina machen Aussätzigen Einspritzungen. Für Aussätzige im Anfangsstadium guter Erfolg"**
**[Sr. I and Sr.V injecting leprous patients. Good success with in the early stages of the disease.]"[196]**

The three recoveries claimed by Sister Innozentia all stayed on at Tabora: "Where shall we go? Who will care for us, if we leave? If we stay, we are well cared for in matters bodily and spiritual", the sister reported their arguments in a letter dated 09.01.1929. It is difficult to say, what spiritual ideas drove these former patients to remain at the camp.[197] We do not know more of their medical histories and how invalid they were at the time of their cure – and how complete their cure really was. Later, in the 1930s, the Director of Medical Services in Tanganyika would describe the somewhat transient successes of Hydnocerol treatments, and he would also criticize the lack of scientific application of the drug.[198] Certainly, by 1932 Hydnocerol treatments were not that attractive for the Tabora patients, and they tried to evade it.[199] By that time, the prospects of a quick injection/chemotherapeutic magic bullet solution to the medical side of leprosy had vanished into thin air. One of the missionaries speculated that, even if the Africans felt stronger after the injections, the reason could just as well be, that they were better

[196] P. Wolfram Meyer, *Tabora: Sr. Innozentia und Sr. Valentina machen Aussätzigen Einspritzungen. Für Aussätzige im Anfangsstadium guter Erfolg,* 1930. PSKO.
[197] Schwester Innozentia, *Aus den Missionen*, in Providentia, 1929. This report is a letter dated 09.01.1929.
[198] See Chapter 6.
[199] Veit Gadient, *Ein Stündchen bei den Aussätzigen*, in Missionsbote der Schweizer Kapuziner in Afrika, 1932.

fed and that their wounds could heal because of the good dressing."[200] A lot of the care work was still being done by the assistants paid by the government. The mission underlined the fact that they worked along the lines laid down and under the guidance of the missionary nurse.[201]

### Medicine at the school (and the mission station)

Apart from the Leprosy settlement, medical work on the mission station focused on services to the mission community. Schools and pupils were hugely important to the Mission. Many "missions were practically boarding schools, where people were educated in social welfare as well as religion," a missionary historian wrote at the end of the colonial period.[202] With their small resources the Capuchin mission tried to cater primarily to their own affiliates. They cared for their health and they imparted knowledge about hygiene and health. From the beginning, the Capuchins were pulling teeth and dispensing medicine at the Mission station in Kwiro, and only if 'the people' did not get relief from the Mission, did these 'Christians' turn to the doctor at the Government hospital.[203] The boarders at the mission school were the prime recipients of medical care dispensed by the Mission. But the health situation in these schools was far from good. There were regular epidemics in the school in Kwiro. This constituted a major problem for the continuation of the mission community. It was a question of the sheer survival of the mission pupils. And it was a problem in terms of the status of the Mission, too. Disease being read as a sure sign for a break in good social relations, it hardly left a good impression with the locals when the impressive mission school building was full of sick pupils: measles was a problem in 1929[204], typhoid in 1931 and, before the new dispensary in Kwiro was equipped, an influenza epidemic afflicted up to 100 pupils at the same time.[205] The missionaries fought hard to keep these outbreaks under control. The example shows that the task of missionary medicine was a matter of sustaining concrete missionary institutions. Catholic mission medicine was a prerequisite to the transfer of the institutional build-up of the Catholic 'separate society' to Africa.

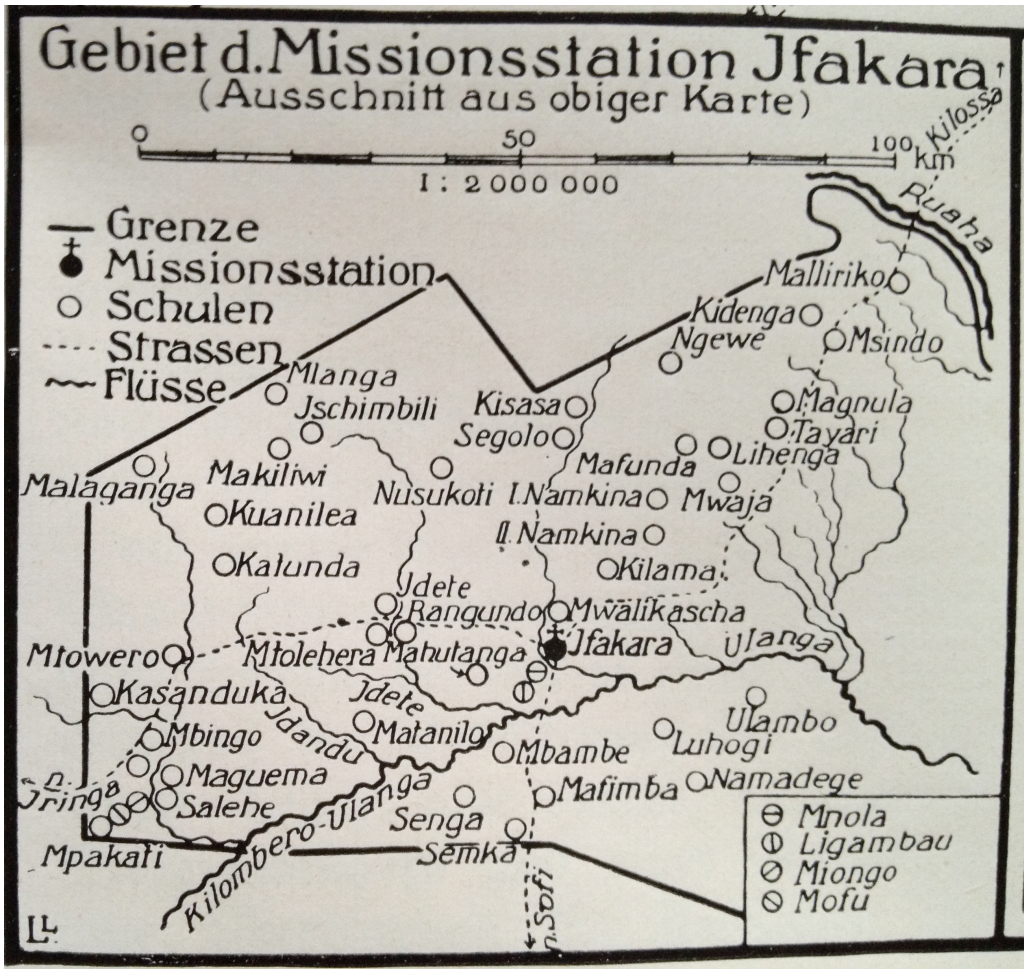
## Ifakara: Mission Work in an Unhealthy Place

Unlike the mountain places Kwiro and Kipatimu, the mission in Ifakara was placed in the flats formed by the Kilombero River - for a long time called the Ulanga River - which meanders through a large valley and is joined by the smaller river Lumemo at Ifakara. The Kilombero

[200] P. Jesuald Loretz, *Bei den Armen Gottes. Erlebnisse eines Aussätzigen-Pfarrers*, in Missionsbote der Schweizer Kapuziner in Afrika, 1933.
[201] Veit Gadient, *Ein Stündchen bei den Aussätzigen*, in Missionsbote der Schweizer Kapuziner in Afrika, 1932.
[202] Severino Zucchelli, *Medical development in Tanganyika*, 1963, p. 24.
[203] P. Guido Käppeli, *Mein Hochwürdiger P. Provinzial. Kwiro, 21.05.1922*, in Missionsbote. Missions-Nachrichten der Schweizerischen Kapuzinerprovinz, 1922; P. Guido Käppeli, *Mein Hochwürdiger P. Provinzial. Kwiro, 08.06.1922*, in Missionsbote. Missions-Nachrichten der Schweizerischen Kapuzinerprovinz, 1922.
[204] Schwester Innozentia, *Aus den Missionen*, in Providentia, 1929.
[205] Gerard Fässler, *Influenza in Afrika*, in Missionsbote der Schweizer Kapuziner in Afrika, 1932.

Valley, a large valley of almost 200 km length and with hardly any gradient, is divided in two natural zones. Ifakara sits at the mouth of the 'Inner' Kilombero Valley, where it opens towards the outer valley parts, an open plain that is more like a basin than a valley.[206] The river has a tendency to flood the valley, but it also provided an important transport system for the entire region and fish for the local population.

Unlike Kwiro and Kipatimu, Ifakara was a mission station with no leprosy camp and with no particular set-up for health care work for most of the 1920s. But Ifakara was located at an important economic and cultural intersection and it had a large number of schools.[207]




**Ifakara Mission station area" Map from 1928 showing 40 schools.**
**It was described then: "Ifakara in the unhealthy lowland plain and threatened by Islam, located on a road full of promises for the future and surrounded by wreath of flourishing schools"**

Confidence was expressed that Ifakara had a great future as the "node in a projected train line that connects the north with the south" and that it was the place of "hope of Christianity".[208]

[206] R. Jätzold et al., *Kilombero Valley*, 1968, p. 16.
[207] At least six "ethnic groups" consider Ulanga as their home. Ifakara was considered a place of the Wambunga, and the Native Authorities there were chosen from Wambunga. Jamie Monson, *Memory, Migration and the Authority of History*, in The Journal of African History, 2000; Maia Green, *Priest, Witches and Power*, 2003, p. 16. For the colonial statistics in the early 1950s see: TNA 461/17/4: *[file] Population*.
[208] *Ifakara*. PSKO: Album Missions-Station Ifakara I. P. Guido Käppeli, *Durch Strom und Wald und Steppe den Menschenseelen nach*, in Seraphisches Weltapostolat des Hl. Franz v. Assisi, 1927, p. 161.

But, of course, since its original foundation Ifakara had been a difficult station for the Benedictines. Before the Capuchin missionaries managed to re-staff Ifakara in 1922 they had been urged by the local Christian community to re-open the Ifakara Mission station on a number of occasions. Whenever Missionaries passed through Ifakara, they were greeted by crowds of children calling out that they were 'Catechumen', i.e. in preparation for baptism by a catechist and by adults who brought presents of eggs and rice.[209] These crowds sang hymns with melodies the missionaries knew from home but interspersed with “an ear-piercing howling" that was "odd and strange" to the missionaries' ears.[210] Instead of taking care of Ifakara from Kwiro, the Mission sent P. Franz Xaver Frei to re-open the station. In 1922 he made the trip of three days into this place considered by the missionaries as a "rallying point of the Muslims".[211]

The Annual Report of the Swiss Capuchin Mission to East Africa called the re-opening of Ifakara the "fourth expedition" of the mission society. This same report of the Capuchin Mission noted that Ifakara was a “station of upmost importance that presents many obstacles, the sort which is not at all a problem in the highland stations.”[212] The houses built by the Benedictines were neglected, the Church a large building but in a sorry state. It was the presence of Islam and disease, however, which made the Mission nervous about Ifakara. The strength of Islam was a problem linked intimately with the social and economic processes that made Ifakara an important place. Since the advance of Islam was seen as a result of the economic leverage of Muslim traders, the mission’s proselytizing work was made precarious by the social complications it had evaded when it concentrated more on the inland stations than on the coastal parts of the assigned mission field. In a letter in 1927 the Mission was still advised that “in Ifakara there is hardly a perspective for successful mission work […] the traders are the worst enemies, that means that most of them are Muslim and that’s why it is very important to get Christian traders.“[213] This letter by a former Benedictine missionary testifies to the view that progress was perceived to be possible, but only if social and economic inroads were undertaken at the same time. 'Kulturarbeit' was necessary.

Another problem was that, up to 1925, Ifakara had no Baldegg sisters at all. Sisters were considered necessary for successful work amongst the female population. In particular, sisters were needed to look after the female boarders, so that they would not be married outside the small Christian community.[214] "If we are successful in raising Christian women, and give our blessings to Christian marriages and families, then these people will be reinvigorated in spirit

[209] Larson and Green nevertheless described the Catholic Community in Ulanga as "almost non-existent" at that time: Maia Green, *Priest, Witches and Power*, 2003, p. 39; Lorne Larson, *History of Mahenge*, 1976, pp. 252-254.
[210] P. Wolfram, *Eine 'Safari' im Missionsland*, in Missionsbote. Missions-Nachrichten der Schweizerischen Kapuzinerprovinz, 1922. P. Emil Baumann, *Ernstes und Heiteres aus einem Briefe von P. Emil Baumann*, in Missionsbote der Schweizer Kapuziner in Afrika, 1923.
[211] P. Franz Xaver, *[Brief] Kwiro, 04.12.1921*, in Missionsbote. Missions-Nachrichten der Schweizerischen Kapuzinerprovinz, 1922.
[212] *Die Schweizer Kapuziner in Afrika. Jahresbericht 1923*, 1924, p. 16.
[213] PADSM 153/3: P. Josef *Letter to Ew. Hochwürden. Kurasini 15.11.1927*.
[214] *Die Schweizer Kapuziner in Afrika. Jahresbericht 1925*, 1925, pp. 8-10, 18-19. See also chapter 5.

and body," the annual report of the Capuchin mission stated in 1925.[215] Controlling 'heathendom' was thus considered as a condition for health. The insalubrious nature of Ifakara was not only due to the "unhealthy climate" in the flood river plains which jeopardized the health of the missionary and made Africans suffer. It was also a resulted of the social life. The reason for a seemingly very high child mortality rate around Ifakara was – apart from the climate – "the ignorance of the mothers, who rarely care better for their children than quadrupeds for their offspring".[216]

P. Franz Xaver had died of relapsing fever in December 1922.[217] But the missionaries continued to live and work in Ifakara (unlike the British administrators who fought bitterly about relocating from Kiberege to Ifakara all throughout the 1930s). P. Franz Xaver was succeeded for a short while by P. Guido Käppeli, who had just recently sensed the insalubrity of Tabora. After all it was not impossible to survive in Ifakara. P. Emmanuel, who had taken over from P. Guido, reported in May 1925 to be sick for the first time in a year, and he liked Ifakara because it was warmer and more fertile than Kwiro. He argued that Ifakara was in fact not so unhealthy, provided you took your regular dose of quinine.[218] But as in many other places missionaries became sick in Ifakara, too. In 1931 P. Emmanuel was transferred from Ifakara to the coast, where he could get better health care. In P. Emmanuel's place as "superior", i.e. head, of the mission P. Hieronymus came to Ifakara.[219]

P. Hieronymus came to stay and shape the Ifakara mission for almost 35 years, from the early 1930s to the mid 1960s. P. Hieronymus had been chaplain in Rorschach, Switzerland before he went to Tanganyika at the end of 1924, when he also joined the Capuchins.[220] While many of his brethren were on a rotation through the different mission stations, Hieronymus, once in Ifakara, stayed there until his death. Hieronymus was always a proponent of 'Kulturarbeit' and mission medical work at Ifakara.

But by the time P. Hieronymus came to Ifakara, the Mission already had a dispensary run by a trained nurse, Sister Arnolda Kury. Sister Arnolda became a founding figure. She too, like P. Hieronymus, was to remain in Ifakara for the rest of her long missionary career in East Africa. Born on March 12, 1902 she trained in nursing in Baldegg in the courses of 1923-4 and after her religious training was fully completed too she left Switzerland for Tanganyika in August 1928.[221]

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[215] *Die Schweizer Kapuziner in Afrika. Jahresbericht 1925*, 1925, p. 24.
[216] *Unsere Mission in Ifakara*, in Missionsbote der Schweizer Kapuziner in Afrika, 1924. This discourse goes back into the early 1900s and German colonial discourse. Wolfgang U. Eckart, *Medizin und Kolonialimperialismus*, 1997, p. 313. Otto Peiper, *Sozial-medizinische Bilder aus Deutsch-Ostafrika*, in Zeitschrift für Säuglingsschutz, 1912; J. M. M. van der Burgt, *Zur Entvölkerungsfrage Unjamwesis und Usumbwas*, in Koloniale Rundschau, 1913. On this discourse of maternal ignorance see chapter 5.
[217] Marita Haller-Dirr, *Bischof Gabriel Zelger*, in Helvetia Franciscana, 1995, table p. 108.
[218] P. Ansgar Häne, *Der Missionär beim Missionär*, in Missionsbote der Schweizer Kapuziner in Afrika, 1925.
[219] *Personalnachrichten aus unserer Mission*, in Missionsbote der Schweizer Kapuziner in Afrika, 1931.
[220] *[obituary] P. Hieronymus Schildknecht*, in ite, 1965; P. Edelwald Steiner, 2010. Do not mistake H. Schildknecht with the White Father Franz Schildknecht, who studied Muslim society in Tanzania for the Roman Catholic Church.
[221] *Aus den Missionen*, in Providentia, 1929; Institutsarchiv Baldegg B IV 11,6: *[file] Baldeggerschwestern welche die Pflegerinnenschule in Baldegg oder Sursee besuchten*.

When the "charismatic, motherly sister with her constant grin from ear to ear", died in 1962 she was buried as a great figure in the history of Ifakara and she is remembered (and almost mythified) in the Mission and in Ifakara to this day as the founder of maternity services and the hospital.[222] The beginning of medical work in Ifakara is almost absent from the sources. Lacking illuminating documentation, we must assume from the argument made above that the care for the health of the missionary staff and in the schools was at the heart of Arnolda's presence. Certainly Sister Arnolda soon started work with Africans from the sphere of the Christian community in Ifakara. But she also worked within the government's campaign against Yaws and treated 1'325 patients for this disease.[223] The following chapters of this thesis will show how Sr. Arnolda made her position in the complex 'medical marketplace'[224] in Ifakara and how the beginnings of mission medicine and the institutions charted in the current chapter have contributed to the configuration of the health system in Ulanga.

## Conclusion

The Swiss came to Ulanga at a time of great changes. After 30 years of quite radical and sometimes bloody shifts in the political, economic and ecological foundations of life in Ulanga, the British slowly established a new colonial administration in the 1920s. The Swiss Capuchin Mission arrived with almost no missionary experience, but they were backed by a Catholic 'mission spring' in Switzerland and they did have a tradition of addressing issues of welfare through house-visits. With the help of the Sisters from Baldegg, the Capuchins re-established Catholic mission structures in Ulanga by making use of the toolkit of Catholic organization, i.e. sturdily organized institutions, and the toolkit of mission, which included 'Kulturarbeit' and, in particular, education and medicine.

Out of this was produced a specific kind of medicine, one that was sponsored by a conservative Catholic movement that had developed in 19th century Switzerland. This was based on new organisations which had responded to the social questions of the times. This kind of medicine was entrenched in the hospice that provided relief to the poor in a colonial situation even though the missionaries had a limited understanding of the moral economies at work. The missionaries learnt to draw from templates that had developed in the colony and adapted their work to the structures of empire. They developed a powerful discourse about poverty, and they staffed and promoted institutions which helped to intervene on behalf of the poor in very

[222] P. Hilmar Pfenniger, *Zum Titelbild; Sr. Arnolda Kury [obituary]*, in Missionsbote der Schweizer Kapuziner in Afrika, 1963; Sylvia Sr. M. Buess, *Schweizer Missionare: Schwester M. Arnolda Kury, 1902-1962, Baldegg*, in Sendbote, 1991; Sr. Marie-Ruth Ziegler, *Im Rückspiegel*, in Baldegger Journal, 2005.

[223] And she seemed to refuse, as did the mission in Sofi, to treat Syphilis.Tanganyika Territory, *Annual Medical and Sanitary Report, 1928*, 1928, p. 16. in the following year all Capuchin fathers' treatments are listed under Mahenge, and now they also show 1565 treatments given against Syphilis Tanganyika Territory, *Annual Medical and Sanitary Report for the year ending 31.12.1929*, 1929, p. 19. In 1933 Sofi is reported to give injections for cases of both Syphilis and Yaws TNA 61/129G: Claude Hollingworth Philips, *Letter MO Mahenge to DMSS. Mahenge 18.09.1933*.

[224] For a discussion of the notion of the marketplace see introduction and chapter 6.

modern ways.[225] In the course of the 20th century, poverty became a major trope that enabled Europeans to intervene in the name of Development. Arturo Escobar speaks of the 'modernization of poverty' that transformed the poor into those in need of assistance.[226] The Swiss Catholic medical mission of the 1920s established the poor African as a person who was assisted in the framework of a modern institution complete with administrative procedures, buildings and European missionary healers. Richard Hölzl has defined the "social mission" as "a combination of a national and (neo-) European calling [Sendungsbewusstsein] with a Christian one." Social mission "collapses long spatial distances within a globally minded, asymmetrical and Eurocentric 'culture of assistance'".[227] It is important to keep in mind that this process impacted heavily on Africa in general, and on Ulanga in particular - and that it did this in ways which were not simply a product of the bourgeois 19th century with its technical, scientific and liberal developments.[228] On the contrary, by sticking to the ideal of *caritas*, Catholic mission medicine kept alive an articulation of "the poor", which was linked to a moral economy not fully congruent with the liberal and secular view of "poverty" in the bourgeois state, but it was compatible (not congruent!) to the colonial state.[229] The larger background to these developments was formed by a highly complex and tense process that had reconfigured 'pastoral power in the 19th century.[230] Replacing the clergy, "secular shepherds" were responsible for the well-being of the humans, which was increasingly measured in terms of worldly goals, like health. Women and care were crucial in developing and disseminating this 'new pastoral power' in the form of 'caring power' which, however, kept a close connection to religious practice and morals.[231]

In taking up medical work in East Africa, the Swiss Capuchin Mission expedited models and activities that were part and parcel of the missionary set-up of the times, and they followed the institutional track laid out by their Benedictine predecessors: health care was meant to assist in saving souls and to build the mission as an institution. Their work was little scientific and laid a heavy emphasis on care, poor relief and on stabilizing the African families living in the vicinity of the mission station. Steeped in the caritas tradition of Catholic and current missionary theories, the Capuchin medical work ideal was gendered and corporative, (as in 'corporatism'). It was gendered especially because it wished to rely on Baldegg sisters 'motherly' capacities.

[225] Altermatt's argument that Catholicism in Switzerland was never modern looks different from the South, i.e. when we see how much the Catholic mission contributed to the construction of modernity in Ulanga. Urs Altermatt, *Katholizismus und Moderne*, 1989 [1991].
[226] Arturo Escobar, *Encountering Development*, 1995, pp. 21-24. Eckert stipulates the almost total absence of social welfare before the 1940s: Andreas Eckert, *Regulating the Social*, in Journal of African History, 2004.
[227] Richard Hölzl, *Soziale Mission*, in WerkstattGeschichte, 2011.
[228] Christoffer H. Grundmann, *Gesandt zu heilen*, 1992, pp. 295-296.
[229] Bruce J. Berman, *Ethnicity, Patronage*, in African Affairs, 1998, p. 314; Anna Laura Stoler et al., *Tensions of Empire*, 1997; Shula Marks, *Colonial Medicine*, in Social History of Medicine, 1997, p. 210. This contributed, one must assume, to the tensions of empire long into the post-colonial era.
[230] Michel Foucault et al., *Geschichte der Gouvernementalität*, 2004. Michel Foucault, *Subject and Power*, in Critical Inquiry, 1982; Michel Foucault, *Omnes et Singulatim*, in The Tanner Lectures on Human Values, 1979; Michael Ruoff, *Foucault Lexikon*, 2007, pp. 161, 180-184.
[231] Annemieke van Drenth et al., *Rise of Caring Power*, 1999, pp. 11, 14-16 especially. Extending this from a Catholic perspective: Annelies van Heijst, *Models of Charitable Care*, 2008.

With its training institute it promoted the Catholic women's professional work not for their own advancement but as social mothers doing 'selfless service'.[232] The image of maternalism was undergirded by the example of the Virgin Mother and Martha, which presented a widely popular foil for the role of women, one that Altermatt has explained as "the Catholic variety of the bourgeois ideals of woman and family."[233]

It was corporative when it tried to assign autonomy to institutional bodies as well as authority over people and fields of social activity. This must not mean that there was no co-operation with the state; sometimes it seemed that the mission's institutions tried to live entirely off the state subsidies, as in the case of leprosy care. Under the conditions of such a weak colonial administration as in Ulanga, corporatism came quite easy and the sections on leprosy care in this chapter show that this cooperation was indeed conducted in a rather relaxed way.[234] Michael Jennings's argument that it makes little sense to distinguish strictly between missionary and secular medical systems at that time is therefore not incorrect.[235]

What is argued here and in the next chapters, however, is that there is a need to look closely at the way in which medicine was practiced in a particular place at a particular point in time. If mission medicine was a 'branch of colonial medicine', as Jennings stipulates, this thesis argues that it is imperative to look closely at the concrete, small-scale colonial situation in which it was practiced, because this can uncover where missionary medicine was actually more than 'colonial' in the administrative, secular and capitalist sense that is often implied with the term 'colonial medicine'.[236] Looking closely at the small scale can uncover how and where mission medical institutions laid the foundations for Development in specific ways.[237] In this chapter, I have raised the issue of how a "poor African" was created through local missionary practices as a representation, but - more importantly - as a receiver of welfare. This thesis will not follow the representation of the "poor African" in Switzerland or even how spiritual ties between donors and recipients were imagined in Switzerland.[238] It will try to see how the 'social mission' was a historical process happening in Africa. But with even more emphasis the following chapters will

[232] This cannot be taken for granted, as the Catholic women's conservative feminism and their aspirations to professionalization rubbed against a part of the elite Church, who was much more conservative and felt that the mother's place was within the private sphere only. Sonja Matter, *Katholizismus, Frauenbewegung und soziale Sicherheit*, in Schweizerische Zeitschrift für Religions- und Kulturgeschichte, 2011, pp. 516-519.
[233] Urs Altermatt, *Katholizismus und Moderne*, 1989 [1991], p. 46.
[234] Walter Bruchhausen, *Medicine Between Religious Worlds*, 2009.
[235] Michael Jennings, *Healing of Bodies, Salvation of Souls*, in Journal of Religion in Africa, 2008.
[236] Well presented in Anna Crozier, *Practising Colonial Medicine*, 2007. It seems to be a complication that colonialism, biomedicine and medical modernisation ran parallel and thus are sometimes being used almost as exchangeable. Indeed medicine was important to the colonial project: David Arnold, *Medicine and Colonialism*, 1993. But colonial power can easily be overestimated and historians have been very careful to point out the social history dimensions of 'colonial medicine' and have, in general, been careful not to look carefully at the weight and specificity of the 'colonial' factor in their studies, even when they use the label in their titles. Waltraud Ernst et al., *From History of Colonial Medicine to Plural Medicine in a Global Perspective*, in NTM Zeitschrift für Geschichte der Wissenschaften, Technik und Medizin, 2009; Shula Marks, *Colonial Medicine*, in Social History of Medicine, 1997.
[237] Such a way always contributes to huge comparisons, as it is essentially interested in finding variations. Charles Tilly, *Big structures, large processes, huge comparisons*, 1984.
[238] Marita Haller-Dirr, *Du schwarz, ich weiss*, 2012; Patrick Minder, *Suisse Coloniale*, 2011.

stick to another topic that has been laid out in this chapter: the thesis will try to explain institutional set-up and trajectories which were fundamental to the life of and with institutions and ideas of Development. While this chapter has mainly looked at the taking over and extension of the Benedictine foundations, the next chapters will try to locate the missionary practice within the extension of state medicine to the rural areas.

Msimbazi 1923, Sr. Deotilla pulls a tooth.

The caption in the album made a somewhat ironic comment about the obviously staged character of the photo. The 'patients' are probably the assistants of Sr. Deotilla. Note also the drug-store in the back.[1]

In-patients at the Msimbazi hospital, ca 1926

[1] *Simbasi. Sr. Deotilla zieht Zähne,* ca 1923. PSKO.

Mahenge Government Hospital, probably 1928[2]

Mahenge Hospital staff, probably 1928, maybe including some of the dressers during their training in Mahenge, certainly with "two Indian doctors".[3]

[2] [from PSKO]
[3] [from PSKO, also printed in *Die Schweizer Kapuziner in Afrika. Jahresbericht 1930/31*, 1931, p. 359.]

# Chapter 2 Rural State Medicine in the 1920s and 1930s

From the mid 1920s, the principles and practices of the colonial government established close bonds between health care and the rural administration. Colonial 'state medicine' had often excluded entire categories of the population and took its impetus from a sanitation syndrome that produced harsh regimes of hygiene rather than an interest in the well-being of citizens.[1] These attempts at 'state medicine' in the form of segregating public health regimes are not the focus of this chapter. This chapter looks at 'state medicine' in a marginal region and discusses interventionist colonialism in the 1920s as a process which extended the functions of state into Ulanga – and established a local state in which 'state medicine' was conceived of as a service to be extended to all Africans, albeit at a hesitant pace and with a very sparse structure.

This new style of health care in Africa was based on the establishment of a network of villages with primary level health care institutions providing services that, if assessed by biomedical standards, varied widely in their quality. The chapter presents the making of this set-up as a formative process for 'rural' institutions within a broader history of colonial statehood.

## Governance and the Political Economy of Rural Health Care Systems

In the mid-1970s, historians looked at the development of ill-health as a corollary of the development of rural systems of exploitation in colonial times. Helge Kjekshus, D.E. Ferguson and Meredeth Turshen have argued that medicine in Tanganyika did not help in a situation of the new structural problems produced by capitalist encroachment.[2] However, health systems cannot simply be reduced to functions within an exploitative mechanism. As 'centres of calculation', they were the source of the 'facts' on which the knowledge prevalent at the time and

[1] Arnold talks of medicine in 'enclaves': David Arnold, *Medicine and Colonialism*, 1993; Maynard Swanson, *Sanitation Syndrome*, in Journal of African History, 1979; Myron J. Echenberg, *Black Death, White Medicine*, 2002.
[2] Meredeth Turshen, *Impact of Colonialism*, in International Journal of Health Services, 1977, p. 30; Meredeth Turshen, *Political Ecology of Disease*, 1984; D.E. Ferguson, *Politcal Economy of Health and Medicine*, 1980; Helge Kjekshus, *Ecology Control and Economic Development*, 1996 [1977].

diverse actions were based.[3] Even if ill-health was a product of the colonial encounter, the capacity to heal, the role of medical services and institutions in the fabrication of society, of knowledge and of politics is complex and entails a range of different actors and forms of agency.[4] In African contexts the study of the microphysics of power, (meaning that power is not exerted merely with the brute force of a sledgehammer, but flows multidirectionally within in a field) has shaped the understanding of the historical process.[5] The microphysics in interwar Ulanga was shaped by the thinness of the colonial state: a very small number of British colonial staff (in Ulanga they were by far outnumbered by the missionaries) nevertheless held a considerable bureaucratic power over the district. Based on very uncertain knowledge and colonial understanding of how 'the mandate' was to be implemented, they established an administrative system for a rural periphery, a skeleton state that was meant to cover a territory. The challenge for rural governance in the field was to find the balance between authoritarian service delivery that helped maintain 'peace' in the district and allowed 'control over a territory ' and re-aligning peasant production for export. Expediting income from taxation was the priority for administrators and was, at the same time, needed for state functions and the building of structures of governance, such as policing, and provision of state services like schools and health care.[6] The "dual mandate of extraction and control"[7] thus also contained an element of social development. Jamie Monson has shown in her discussion of the government attempts to enforce cotton production in the Kilombero valley that farmers responded in complex ways to these government measures.[8]

## Indirect Rule in Ulanga and Famine measures as Development

Colonial administrators depended on a series of local collaborators. Indirect rule, in the years from 1928 to 1945, tried to turn chiefs into "mouthpieces of the colonial state."[9] Yet this process was not straightforward. Lorne Larson's research shows that in Ulanga, Indirect Rule

[3] Richard Rottenburg, *Far-fetched facts*, 2009, pp. 87-88. Specific forms and contents of knowledge are the result of particular styles of doing things that "cook" information: Peter Burke, *Social History of Knowledge*, 2000, p. 11; Pierre Bourdieu, *Specificity of the Scientific Field*, 1998 (1975); Bruno Latour, *Science in Action*, 2001 [1987]; Lorraine Daston, *Science Studies and the History of Science*, in Critical Inquiry, 2009. An example for complex way in which a system of knowledge was constructed so that it gave meaning to a changing world see Patrick Harries, *Butterflies and Barbarians*, 2007, p. 2. An argument for African medical knowledge not as held collectively, but composed socially: Steven Feierman, *Socially Composed Knowledge*, 2005.

[4] Megan Vaughan, *Healing and Curing*, in Social History of Medicine, 1994; Nancy Rose Hunt, *Colonial Lexicon*, 1999; Julie Livingston, *Debility and the Moral Imagination*, 2005; Ludmilla Jordanova, *The Social Construction of Medical Knowledge*, in Social History of Medicine, 1995; Mary-Jo Delvecchio Good, *Cultural Studies of Biomedicine*, in Social Science & Medicine, 1995. The role of science in the empire has been a focus of research in recent years, see e.g.: Sujit Sivasundaram, *Scienes and the Global*, in Isis; John M. MacKenzie, *Introduction*, 1990.

[5] Jean Comaroff et al., *Revelation and Revolution I*, 1991; Jean Comaroff et al., *Twenty Years After Of Revelation and Revolution*, in Social Sciences and Missions, 2011; John L. Comaroff et al., *Revelation and Revolution II*, 1997; Peter Geschiere et al., *Introduction*, 2008. The concept is fundamental to Peter Pels, *Politics of Presence*, 1999.

[6] John Iliffe, *Modern History of Tanganyika*, 1979, chapters 9 and 10; D. M. P. McCarthy, *Organizing Underdevelopment*, in International Journal of African Historical Studies, 1977.Hailey listed the responsibilities of N.A. in the African 1938 edition: Malcolm Hailey, *African Survey*, 1938, pp. 440-441.They included a range of regulatory duties on production and sale of agricultural goods.

[7] Jamie Monson, *Canoe-Building under Colonialism*, 1996, p. 201.

[8] Jamie Monson, *Rice and Cotton*, 1995.

[9] Isaria N. Kimambo, *Penetration and Protest*, 1991, p. 86.

legislation did not result in as much of a change in the set-up of local administrative structure as had been expected by the British. It was still largely founded on the collaboration by the very same chiefs identified in German times. Most important, indirect rule did not deliver the amount of intergroup cooperation in economic terms which the colonial government and administrators had hoped for. On the contrary, it made inter-tribal contrast starker. Conflict and competition was rife and many 'Native Authorities" were regularly challenged by their 'subjects' as well as by colonial administrators.[10] Still, amongst a great number of weak chiefs, the 1930s in Ulanga also saw some "dominating" personalities, some of them being in the nature of "modernizing traditionalists".[11]

The establishment of even a weak interventionist colonial state in the 1920s brought the duty of sustaining the population to the desk of the rural colonial administrator. On top of the pile of priorities was the task of implementing a mix of institutional measures and humanitarian campaigns against famine.

The British mandate had started in a period of devastating and widespread famine in Tanganyika.[12] Colonial situations often created new challenges for Africans in times of famine. At the same time, the European administrators' understanding of famine and famine control was rather limited.[13] Beyond famine there was a not only an African "bush-food science" but a whole universe of social health medicines and of practices meant to heal the land.[14] Therefore, if famine control must be viewed as the beginning of comprehensive social development interventions by the state in the rural areas, it is also an early testimony for iatrogenesis and the mechanics of self-interest at play in Development.[15] Famine endangered African lives, destabilized society, and

[10] Lorne Larson, *History of Mahenge*, 1976, pp. 224-232.
[11] John Iliffe, *Modern History of Tanganyika*, 1979, p. 329; Terence Ranger, *Invenvtion of Tradition*, 2012; Lorne Larson, *History of Mahenge*, 1976, p. 268. Towegale bin Kiwanga I was a one of the clever and initiative chiefs who made best use of the system of indirect rule: Lorne Larson, *History of Mahenge*, 1976, pp. 272-289; A. T. Culwick et al., *Ubena of the Rivers*, 1935; Jamie Monson, *Memory, Migration and the Authority of History*, in The Journal of African History, 2000.see also Jamie Monson, *Tribal Past*, 2005; E. K. Lumley, *Forgotten Mandate*, 1976, p. 124.
[12] Gregory H. Maddox, *Njaa*, in The International Journal of African Historical Studies, 1986, pp. 31-32.
[13] Marius Fortie, *On Foot through Tanganyika*, in The Scientific Monthly, 1938, p. 543; David Arnold, *Famine*, 1988; Megan Vaughan, *Story of an African Famine*, 2006 [1987], is an example of a famine produced at the end of an interventionist period; John Iliffe, *African Poor*, 1987, pp. 156-162; John Iliffe, *Famine in Zimbabwe*, 1990, pp. 68-88; Thaddeus Raymond Sunseri, *Famine and Wild Pigs*, in Journal of African History, 1997; James G. Ellison, *A Fierce Hunger*, 2003; Nancy Joy Jacobs, *Environment, power, and injustice a South African History*, 2003; Phoofolo Pule, *Face to Face with Famine*, in Journal of Southern African Studies, 2003; Diana Wylie, *Starving on a Full Stomach*, 2001.
[14] A. R. W. Crosse-Upcott, *Ngindo Famine Subsistence*, in Tanganyika Notes and Records, 1958. What a famine was in the eyes of the people of Ulanga was a matter of definition. Notoriously cynical Rooke Johnston, District Commissioner in Kiberege in 1939, who later became infamous for his rude Sleeping Sickness resettlement policies in Liwale as a P.C., had difficulties to accept that famine was, when there was no rice available. On famine and social health and the role medicines (*dawa*) played in healing the land: James Giblin, *Precolonial Politics*, 1996, pp. 129, 136-145; Steven Feierman, *Struggles for Control*, in African Studies Review, 1985; Steven Feierman, *Peasant Intellectuals*, 1990; Jamie Monson, *War of Words*, 2010, p. 39.
[15] This term is medical, and critiques the failure of expert knowledge and professionalism in practice, when it produces harm. In medicine as well as development practice the principle applied today is that of "do no harm". Iatrogenesis however offers a theoretical apparatus more helpful for analysis. Ivan Illich's concept of iatrogenesis includes the self-interest by professionals (as "social iatrogenesis") as well as "cultural iatrogenesis", which alludes to the destruction of knowledge about healing. Ivan Illich, *Limits to medicine*, 1988 [1976], pp. 16, 42; Aram Ziai et al., *Illich*, in Zeitschrift für Entwicklung und Zusammenarbeit, 2003. Illich's argument deserves a global history extension, looking at "colonial iatrogenesis". Studies on

– hurting the administrators – meant that entire parts of the country were exempted from tax.[16] From the 1920s and 1930s in Ulanga, as in many other places in Africa, chronic malnutrition rather than spells of famine became rife.[17]

Officers were pressing for sustained change in productive and distributive systems as a way to prevent famine. When famine situations arose, British District officers invested in a range of measures, from spending tax money to buy food, to repealing regulations that restricted hunting. Despite this, famine relief measures were not necessarily successful. Colonial officers explained their failure as a result of a lack of 'development'. The attempt to assist the population of the Ruaha/Luhanyando valley in a situation of acute famine was a failure because transport of the food was quite impossible because of the lack of infrastructure. In the end, the food was used at the places that could be reached easily, not least at one of the most important schools in the area - at Izongo.[18] Famine relief thus strengthened 'modern' institutions and disfavored remote areas. These dynamics were understood by the missionaries in no unclear terms, when they reported to their Swiss supporters that "hunger brings people to God".[19] When missionaries engaged in fighting acute famine, they did so mostly by giving food in exchange for work. Work, to their eyes, also had a moral quality that could counterbalance the moral defects of African (and capitalist) prodigality.[20]

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the political economy of health and the political ecology of disease in the colonial world can still contribute to such a discussion: D.E. Ferguson, *Politcal Economy of Health and Medicine*, 1980; Meredeth Turshen, *Political Ecology of Disease*, 1984; Shula Marks et al., *Political Economy of Health*, in Journal of Southern African Studies, 1987.

[16] Government always pushed agricultural production, but often there was also a considerable amount of self-interest, as in the plant-more-crops campaign which was started in 1932. D. M. P. McCarthy, *Organizing Underdevelopment*, in International Journal of African Historical Studies, 1977; David Anderson, *Depression*, in African Affairs, 1984. Ulanga also saw the introduction of a number of measures that "drastically altered" the economy of the Ulanga district at that time: these measures included the promotion of cotton as a cash crop and market regulations. The way Larson presents this, it was mainly an extractive policy. Lorne Larson, *History of Mahenge*, 1976, pp. 289-320. The surplus-production argument is the general argument of Monson's thesis: Jamie Monson, *Agricultural Transformation*, 1991. Jamie Monson, *Agricultural Transformation*, 1991, pp. 332-333; Gregory H. Maddox, *Njaa*, in The International Journal of African Historical Studies, 1986; Deborah Fahy Bryceson, *Food insecurity and the social division of labour in Tanzania, 1919-85*, 1990.

[17] John Iliffe, *African Poor*, 1987, 160. The issue of food shortages and famine has raised considerable debate in Tanzanian historiography. Juhani Koponen, *People and Production*, 1988, pp. 126-127; Juhani Koponen, *Famine, Flies, People and Capitalism*, 1989. The area of Ruaha/Luhanyando would undergo regular food shortages for almost all the years from the late 1920s that are documented in the archives used for this research. Another problematic place was the area of the mission in Sofi where for a series of years the missionaries reported famine situations so severe that in their attempt to help they worked themselves to the brink of collapse. PADSM 208/Sofi 1: Pater Oskar Kessler, *Chronica Sofiana 1929*; PADSM 208/Sofi 1: Pater Oskar Kessler, *Chronica Sofiana 1930*; PADSM 208/Sofi 1: *[Chronik Sofi] 1933*. Famine was still a problem in the 1960s: DAK folder 'parishes various shauris': Pater Fridolin Fischli, *Letter to P. Gerard and P. Generalvikar. Sofi, Palmsonntag 1961*.

[18] TNA 61/334/G/32: *Letter PC EP to DO Mahenge, 09.12.1932*; TNA 61/334/G/32: *Telegram PC EP to DO Mahenge, 09.12.1932*; TNA 61/334/G/32: *Letter DO Mahenge to PC EP. Mahenge 29.11.1932*; TNA 61/341 H: *Letter PC EP to ADO Kiberege. 22.02.1933*.

[19] *Durch Hunger zum Herrgott*, in Missionsbote der Schweizer Kapuziner in Afrika, 1929. For examples in the 1940s see chapter 4 with examples from Ruaha and also Lorne Larson, *History of Mahenge*, 1976, page 308-309: fn 358, 359. Famine measures also provoked resistance: John Iliffe, *Famine in Zimbabwe*, 1990.

[20] PADSM 153/3: Hieronymus Schildknecht, *Quartalsbericht von Ifakara: Pfingsten 1935*; PADSM 153/3: Hieronymus Schildknecht, *Quartalbericht von Ifakara. Ostern bis Pfinsten 1938*; P. Ansgar Häne, *Die Haushaltungskosten des Negers*, in Missionsbote der Schweizer Kapuziner in Afrika, 1927. In powerful language and with a punt at the anti-figure to righteous farmers in Ulanga, the "Migros-Indians": P. Jesuald Loretz, *Volk und Boden*, in Missionsbote der Schweizer Kapuziner in Afrika, 1934.

## Dispensary Services and the Colonial Rural Health system for 'Natives'

Similar to the fight against famine, the colonial state in the 1920s fought epidemic disease in campaign-style but subscribed to the installation of forms of permanent intervention as well. A native medical service for rural Africa was devised in many areas of Africa at that time. Since sanitation in comparison to curative services had proved rather unpopular and impossible to implement under indirect rule, the backbone of rural health care was the dresser in a 'dispensary', where Africans could find treatment for endemic health problems like yaws or hookworm.

The basis for 'biomedical' rural health care at the time was the 'tribal dressing system'. The British introduced medical services for Africans in rural areas in Tanganyika in the second half of the 1920s. This was an empire-wide development. The Rockefeller Foundation had pushed the development of 'dispensary services' in the rural areas.[21] The dispensary system that developed in the 1920s and 1930s in Africa had a lasting impact on health care systems on the continent. It established a net of primary health institutions all over the continent, concentrating on its central and eastern parts.[22]

Some of the curative campaigns of the 1920s, particularly the one against Yaws, had proven to be popular with many Africans. When the man in charge of these campaigns, Owen Shircore, became Director of Medical Services in 1924, he began to set up a basic rural health care system based on built infrastructure, and on the dresser in the dispensary.[23] The first batch of staff was Nyasaland-trained African "dispensers" but soon Tanganyika introduced its own training format.[24] From 1926, so-called 'tribal dressers' were trained:

> "for the purpose of treating minor medical cases including hookworm and intestinal parasites, rendering first aid in surgical conditions, and promoting the elementary principles of hygiene." [25]

Based on this medical portfolio, a segregated indigenous but entirely 'scientific' rural health service was meant to develop:

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[21] Michael Worboys, *Colonial Medicine*, 2003, pp. 75-77. Anne-Emanuelle Birn, *Marriage of Convenience*, 2006. Qiusha Ma, *The Peking Union Medical College and the Rockefeller Foundation's medical programs in China*, 2002. Rockefeller first pushed dispensaries in America and France John Farley, *To Cast Out Disease*, 2003.

[22] With examples from Congo and Uganda Maryinez Lyons, *Power to Heal*, 1994, here p. 223, also pp. 207, 209. On British Sudan Heather Bell, *Frontiers of Medicine*, 1999, pp. 27-28. On Rwanda and the beginning of the dispensary system there between 1925 and 1933: Anne Cornet, *Politiques de santé et contrôle social au Rwanda*, 2011, pp. 31, 94, 116-118. On Kenya see: Osaak A. Olumwullah, *Dis-ease in the Colonial State*, 2002, pp. 249-253. On Tanganyika see: Gerardus Maria van Etten, *Rural Health Development in Tanzania*, 1976, pp. 27-28; Anna Crozier, *Practising Colonial Medicine*, 2007, p. 83. Ann Beck, *Britisch Medical Administration in East Africa*, 1970, pp. 132-134; Ann Beck, *Medicine, Tradition, and Development*, 1981, pp. 15-19. Detailed work on dispensaries and dressers from Walter Bruchhausen, *Medizin zwischen den Welten*, 2006, pp. 102-140. Walter Bruchhausen, *Medicine by Non-doctors? 'Tribal dressers' in Tanganyika Between Health Care and Politics, 1926-1951* (paper presented at the Imagining and Practising Imperial and Colonial Medicine, 1870-1960, 2008); John Iliffe, *East African Doctors*, 1998, pp. 34ff; Patrick Thomas Malloy, *Holding by the Sindano*, 2003; Oswald Masebo, *Society, State and Infant Welfare*, 2010.

[23] David F. Clyde, *History of the Medical Services of Tanganyika*, 1962, pp. 118-119; David F. Clyde, *Tanzania*, 1980, pp. 103-104; Helmut Goergen; Walter Bruchhausen; Kirsten Kuelker, *History of Health Care in Tanzania*, 2001, pp. 13-15.

[24] David F. Clyde, *History of the Medical Services of Tanganyika*, 1962, p.118.

[25] TNA 61/129 vol I: Tanganyika Territory Chief Secretary to the Government, *Circular No 68 of 1926: Tribal Dresser. DSM 01.12.1926*.

> "The aim of a tribal dresser system is understood to be a service which will gradually develop into a Native Public health service and whose growth and responsibilities should correspond with the growth and responsibilities of Native Authority. It differs in its ideals from the latter in that Native Authority are attempting to develop themselves from existing native laws and customs, whereas the native medical service, at present at least, dissociates itself completely from native medicine and it is only when certain forms of the latter, particularly plant extracts, are tested and approved by European methods that they can be accepted. Besides, free treatment is practiced in the one system, private payment in the other. The Medical Department will therefore have to teach and regulate the native medical service until such time as the latter can do without its support, but while this is being done the Native Authorities should take over as much as possible of the financial and disciplinary responsibilities of the service."[26]

The medical 'help for self-help' development agenda laid out in this document from 1934 is all about the transfer of the principles of 'modern' (which meant European) medicine. In terms of the medicine practiced, the 'dresser system' was not meant to be 'primitive' in the sense of being the 'medicine of the primitives'.[27] The medical modernization of the tribe was not meant to happen through established African institutions. Native Authority Dispensaries were meant to offer basic but exclusively biomedically informed services to the population.

The dispensaries were maintained from the Native Treasuries and were therefore a part of the pseudo-ethnic administrative system of indirect rule. The dressers on whom this medical modernization was meant to rely were trained in government hospitals for three months only and then sent to their posts, where they manned the peripheral arms of an almost entirely African-staffed health service. European doctors were rare in rural areas and together with their support staff, their practice was, with the exception of vaccination campaigns, mostly confined to the 'government hospital'.[28] Alongside a doctor (and often all on their own), Indian and African Assistants worked in these hospitals, of which there was only one in Ulanga, located at Mahenge. The hierarchies and terminology in this medical service were racial: the white doctor was a (Senior) Medical Officer, Indian health workers were called "Sub-Assistant Surgeons" (SAS), while the training programme for Africans produced "Hospital Assistants" or "Medical Assistants".[29] In Ulanga, time and again, there was no Medical Officer and an Indian Sub-Assistant Surgeon stepped in - if such an individual was available.[30] In fact, the majority of the staff in the state's health system in Ulanga was African and the public sector dispensary system in the peripheral rural areas was run exclusively by Africans.

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[26] TNA 13571/II: *Extract from a memorandum on tribal dressers by the director of medical and sanitary services dated 08.06.1934*.

[27] Patrick Harries et al., *Medizin und Magie*, 2012.

[28] For an outline of the concept of health service organization based on a system of (Senior) Medical Officers in government hospitals and their supportive staff see: Anna Crozier, *Practising Colonial Medicine*, 2007, pp. 72-85.

[29] Sub-Assistant Surgeons were trained in India. The first SAS programs had started as a rapid proto-professionalization process tied to the establishment of dispensaries in India during the 1820s to 1840s. Projit Bihari Mukharji, *Nationalizing the Body*, 2009, pp. 3-6.With African training being extended, at the end of the colonial period the difference between Indian SAS and African Medical Assistants was largely one of terminology. John Iliffe, *East African Doctors*, 1998, p. 61; Lesley Doyal et al., *The political economy of health*, 1983 [1979], p. 259.

[30] The first SAS came in 1920 to Mahenge Hospital. TNA 450/34/3 District Office Mahenge, *Letter to Principal MO. Mahenge 07.10.1920*; TNA 450/34/3 *Letter from Medical Office, Mahenge to Dir of Med. Services. 06.04.1928*; TNA 450/34/3 James Septimus Armstrong, *Letter MO Mahenge to Dir Med. Services. Mahenge 24.05.1929*.On the SAS Mr. Purundare see TNA Acc.450/HE/178/16: Gerard Fässler, *Letter to Direct. of MS, Kwiro 17.09.1935*.

A dresser worked largely un-supervised, equipped with the Kiswahili "Book of the Dresser", the *Kitabu cha Madressa*, which explained the aetiology and treatment of some of the most common diseases.[31] This book was still in use as the main teaching tool in 1946.[32]

The buildings that housed the N.A. (Native Administration) dispensaries were not intended to be impressive. Compared to the prestigious modernity of Western hospital architecture of the time, the modest level of modernity expressed by the dispensary building is significant and overtly racial. The medical administration wrote: "a simple wattle and daub structure is all that is required".[33] In their reasoning, medical planners combined the practicalities of minimal material input with those of easy access (in terms of acceptability).[34]

With limited input the dresser system was meant to cover the rural population as best as possible. "A dispensary and midwife within reach of every village" had been the intention of the Director of Medical Services, Owen Shircore.[35] Dressers were to be spread out all over the territory, one dresser per 5,000 people, and dressing stations at 15 miles distance to each other, replicating a colonial aesthetic approach at systematic planning which created equidistant spheres of influence and administration.[36] In 1930, 288 dressers worked at these posts, sometimes called 'dressing stations' rather than dispensaries, all over Tanganyika.[37] Training remained cursory and in many places during the 1930s you would find dressers who had never passed a training course but had started as sweepers in the dressing stations.[38] From a stray source it seems that the entire training scheme was understood as temporary and was not meant to be continued into the future.[39] Nevertheless it was to remain the trestle of rural state medicine well into the late colonial period.

[31] The handbook explained and gave quite concrete advice on what diseases certain symptoms might signify; how to clean wounds and with which tools; how to prepare solutions, like Lysol or citric acid and many other things. The book was written by Dr. John Owen Shircore, the Director of Medical and Sanitary Services of Tanganyika Territory, in 1926 and saw a second edition in 1934 TNA 13571/I: Tanganyika Territory Director of Medical and Sanitary Services, *Tanganyika Territory: Dr. Shircore's Instructions for Tribal Dressers (2nd edition, first edition 1926)*.
[32] TNA 461 16/8: *"Tribal Dispensaries"*, folio 202.
[33] TNA 61/129 vol I: Tanganyika Territory Chief Secretary to the Government, *Circular No 68 of 1926: Tribal Dresser. DSM 01.12.1926*.
[34] This can be grasped from statements made on maternities in Dar es Salaam cited in David F. Clyde, *Tanzania*, 1980, p. 100.
[35] According to his successor, R.R. Scott. See: R.R. Scott, *The medical training of Africans in Tanganyika Territory*, in South African Medical Journal, 1942, p. 86.
[36] On these kinds of geographies and the negative consequences see Charles M. Good, *Steamer Parish*, 2004, p. 194. For a powerful account of how missionaries excelled at making use of such policies, see Al Imfeld, *Auf den Strassen zum Himmel*, 2013, pp. 63-69.
[37] The total African staff in the medical department in 1928 was over 2'000, of which about half were sanitary labourers: Tanganyika Territory, *Annual Medical and Sanitary Report, 1928*, 1928.
[38] TNA 61/129 vol I: Tanganyika Territory Chief Secretary to the Government, *Circular No 68 of 1926: Tribal Dresser. DSM 01.12.1926*.
[39] TNA 61/129 vol I: *Letter Acting DO Kilosa to PC E.P. 23.03.1929*.

## The Contribution of the Dispensary System to the Modernization and Indigenization of Local Government

The dresser/dispensary system followed a logic which aimed to strengthen administrative legitimacy in rural areas and was thoroughly interlaced with the system of governance of indirect rule. The medical administration wrote in 1926 that Provincial Commissioners and District Officers "should make every effort to induce [Native Authorities, i.e. the chiefs] to take an active interest in" dispensaries.[40] At the same time Native Authorities were made responsible for a long list of duties, including sanitation, population enumeration and anti-famine measures:

> "The N.A. is empowered to issue orders to be obeyed by natives [regulating...] intoxicating liquors; preventing the pollution of the water [...] preventing the spread of infectious or contagious diseases[...regarding the ] immigration of natives [...] requiring birth and death of any native [...] to be reported [...] exterminating or preventing the spread of tsetse fly [...] requiring any native to cultivate land to such extent and with such crops as will secure an adequate supply of food..."[41]

Energetic colonial district officials would subscribe to this agenda in the late 1930s and early 1940s and push the chiefs to implement respective measures.[42] The missionaries shared the belief that modernized rule was the duty of the African leaders.[43] Chiefs indeed often took an interest in dispensaries and encouraged the provision of curative medicine.[44]

Particularly in places like Ulanga, the dispensaries came to represent the modernizing of village life. Under the nomenclature of closer settlement[45], local society was reorganized into stabilized Native Authority areas of jurisdiction. Built-up structures like chiefs' *'barazas'*, markets, schools and dispensaries fixed the colonial institutions of rule administration within the village. Dispensaries came to be built in 'villages' strung along by the sides of the three or four major roads in Ulanga, rather than just by dirt tracks. Dispensaries became part of a system that constituted the district as a spatial politico-administrative unit.

Dressers themselves were delegated by the colonial system to be "champions of modernity".[46] The Tanganyika Territory Director of Medical Services, R.R. Scott, told a South African audience in the early 1940s that dressers "carry the elements of Western medicine to the

[40] TNA 61/129 vol I: Tanganyika Territory Chief Secretary to the Government, *Circular No 68 of 1926: Tribal Dresser. DSM 01.12.1926*. Patrick Thomas Malloy, *Holding by the Sindano*, 2003, p. 219. Justin Willis, *Administration of Bonde*, in African Affairs, 1993; Gregory Maddox et al., *Introduction*, 2005; John Iliffe, *Modern History of Tanganyika*, 1979, pp. 318-321.
[41] Tanganyika Territory, *Ordinance no.18*. Quoted as in: Gerardus Maria van Etten, *Rural Health Development in Tanzania*, 1976.
[42] A published account is: E. K. Lumley, *Forgotten Mandate*, 1976.
[43] P. Gustav Nigg, *Der neue Sultan der Wapogoro*, in Missionsbote der Schweizer Kapuziner in Afrika, 1934.
[44] See below for Ulanga. See also Oswald Masebo, *Society, State and Infant Welfare*, 2010, pp. 193 ff. Remember how much healing and power were linked in African political culture: Steven Feierman, *Peasant Intellectuals*, 1990; Steven Feierman, *Healing as Social Criticism*, in African Studies, 1995.
[45] The politics of "closer settlement" started in the early 1920s already (1921-1925): Lorne Larson, *History of Mahenge*, 1976, pp. 222-224; Thaddeus Raymond Sunseri, *Wieding the Ax*, 2009, p. 100. See chapter 4 for a detailed discussion.
[46] John Iliffe, *East African Doctors*, 1998, p. 56. In 1933 A.T. Culwick was told by the Provincial Commissioner of the Eastern Province that he should invest in soft instruments rather than force in trying to further "closer settlement". TNA 61/341 H: *Letter PC EP to ADO Kiberege. 18.03.1933*.

furthest corners of the Territory, and thus form the closest link with the rural population."[47] The fact that dressers were literate only in Kiswahili shows another dimension of the specific kind of modernizing ideology in these times. R.R. Scott was rather unhappy with Kiswahili as a scientific language because of a lack of pertinent vocabulary. It became, nonetheless, the administrative language of the dresser.[48] The technical medical language remained English in parts, however, as can be seen from the writings of the dressers. A typical order of medical equipment in the early 1940s would read like this one from Dresser Anselm Amri:

> "*Tafadhali sana Bwana ninaomba dawa* [May I ask you kindly, Sir/Master, I would like to have medicines…] carbon tetrachloride, castor oil, quinine, ammonium, aspirin, santonia[?] magnesium sulphurate, potassium permanganate, iodine fortis, iodoform liniment, soap, gauze, cotton bandages, boric acid, *na vitu vilivyo vibovu ni hivi* [and the things that are broken]: toweli [towel?) and a ear syringe"[49]

Kiswahili language use and vocabulary must be read as a history of power.[50] Patrick Malloy's thesis shows how *Mambo Leo* (translates as: News of Today), the government monthly in Kiswahili language, used a discourse of enlightenment and modernity to discuss medical matters, and how the dressers were trained in Kiswahili because it was considered a 'vernacular' language.[51] Medicine was 'Kiswahilicized': Apart from the textbooks for dressers, like the *Kitabu (kidogo) cha Madressa*, there were other publications that were meant to give information about disease not to the dresser but to a wider audience, probably teachers and native authorities.[52] In the 1930s a series of pamphlets from the government printers, discussed individual diseases. *Magonjwa matatu yanayofisha Taifa letu* (the three diseases that kill our nation) is an example with a particularly striking title, which was, furthermore, revised as a publication in 1935 by the Interterritorial Language Committee, a fact that hints at the social construction of what 'vernacular' means'.[53]

These examples point to the necessity to mediate medical epistemes. Dressers were certainly part of the important group of "African intermediaries" who have received more

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[47] R.R. Scott, *The medical training of Africans in Tanganyika Territory*, in South African Medical Journal, 1942, p. 84. In his history of the medical services, the usually well-informed David Clyde gives a very similar quote (but without reference) of Ross as explicitly described the original 1920s dresser policy under Shircore. David F. Clyde, *History of the Medical Services of Tanganyika*, 1962, p. 119.

[48] R.R. Scott, *The medical training of Africans in Tanganyika Territory*, in South African Medical Journal, 1942. For dressers' administrative practices see: TNA 461 16/8: *"Tribal Dispensaries"*.

[49] TNA 461 16/8: *"Tribal Dispensaries"*, folio 57, dated 10.03.1941.

[50] Johannes Fabian, *Language and Colonial Power*, 1986.

[51] *Mambo Leo* translates as: "News of Today". Patrick Thomas Malloy, *Holding by the Sindano*, 2003, pp. 199, 226-133, and entire chapter 195 from p. 240. On the issue of vernacularism as an episteme see: Helen Tilley, *Global History, Vernacular Science*, in Isis, 2010. For a study how knowledge is reshaped in the process of 'vernacularisation' in the context of mission see Birgit Meyer, *Translating the Devil*, 1995, chapter 4.

[52] I have not looked at these publications in detail. Malloy argues that only the *Kitabu* and a second publication by N. Chilton: *Magonjwa Yaletwayo na Vimelea na Matibio Yake* (A description of the common parasitic diseases of E.A....., DSM 1936) were meant as technical handbooks for dressers. From this I conclude that the others were part of the enlightening discourse. On the dresser training books see also Oswald Masebo, *Society, State and Infant Welfare*, 2010, pp. 203-205.

[53] Originally published probably in the early 1930s this work discussed venereal diseases and alcoholism *Magonjwa matatu yanayofisha Taifa letu*, ca 1930. Patrick Thomas Malloy, *Holding by the Sindano*, 2003, pp. 342-345. For a list of publications see Library of Congress. African Section. et al., *Official publications of British East Africa*, 1960. which is available online (http://heinonline.org). Helen Tilley, *Global History, Vernacular Science*, in Isis, 2010.

attention from historians in the last decades.[54] African hospital assistants, dressers or birth attendants[55] occupied a complex 'middle' position. Medical historians have concentrated on the medical and cultural role of these 'middles' in the process of translating biomedical into local medical concepts.[56] The 'middles' were in an ambiguous position in the power structure. Lyons has shown that Medical Assistants not only had access to certain forms of prestige through status symbols like bicycles, but that 'middles' were also marginal when they missed to service obligations towards their kin. Medical Assistants also became increasingly frustrated with the glass ceiling to their professional careers.[57] Medical workers propagated new lifestyles and made claims to new notions of honor with new demands on ethical behavior and moral economies.[58] The constitution of this class was a central process of the colonial encounter.[59]

There were many different roles and categories of middles. Not all of them were in state services, but those who were took important institutional positions and must be seen in their "continuous role as 'gatekeepers', or brokers (honest or not) between subject populations and external sources of power/patronage." [60] At an institutional level they were hosts and gatekeepers of resources and institutions as well as translators of knowledge medical, moral and material. Nancy Rose Hunt has pointed out another central aspect of the presence of these middles: their cultural practices, often based on interaction with local demand, blurred contrasts between state and missionary medicine.[61]

## Demand and Curative Medicine

The dresser system was a curative one. Preventive services were the domain of African District Sanitary Inspectors,[62] and for Maternal and Child Welfare a separate system of welfare clinics had been devised at about the same time.[63] The quality of medical standards in tribal dispensaries was a subject of great concern and considerable polemics within the medical administration. In the mid-1940s, a new Director of Medical Services, P.A.T. Sneath, took office and challenged the dispensary system as being dysfunctional.[64] The failure of the dresser system

[54] Benjamin N. Lawrance et al., eds., *Intermediaries, Interpreters and Clerks*, 2006. For late colonial Tanganyika see Andreas Eckert, *Herrschen und Verwalten*, 2007.
[55] See chapter 5.
[56] Walima T. Kalusa, *Language, Medical Auxiliaries*, in Journal of Eastern African Studies, 2007; Markku Hokkanen, *Cultural History of Medicine(s)*, 2010; Nancy Rose Hunt, *Colonial Lexicon*, 1999, pp. 2,10, 12, 23 (where she also notes, that "lows" as much as "middles" engaged in translations), and p. 161.
[57] Maryinez Lyons, *Power to Heal*, 1994, pp. 204, 220.
[58] John Iliffe, *Honour*, 2004, pp. 246-251.For a longer perspective on respectability see Robert Ross, *Status and Respectability*, 1999.
[59] John Iliffe, *Tanganyika under German Rule*, 1969, p. 186.
[60] Ralph A. Austen, *Colonialism from the Middle*, in History in Africa, 2011, pp. 21-22.
[61] Nancy Rose Hunt, *Colonial Lexicon*, 1999, p. 161. And with varied attitudes towards African medicine as well: Markku Hokkanen, *Cultural History of Medicine(s)*, 2010, p. 153.
[62] David F. Clyde, *History of the Medical Services of Tanganyika*, 1962, p. 118.
[63] Oswald Masebo, *Society, State and Infant Welfare*, 2010.
[64] P.A.T. Sneath who was Medical Director in the 1940s was particularly outspoken. Iliffe says that the political administration , which felt the popular dispensaries were necessary, held out successfully against the medical man. John

to produce minimum medical standards of treatment had been openly addressed already in 1933:

> "The systematic inspection of a large proportion of these dispensaries by Medical and Health Officers during 1933 revealed the fact that though many of them did undoubtedly do useful work there was a tendency on the part of dressers to undertake forms of work for which they were not trained or qualified, that misdiagnosis led to wastage of drugs and sometimes to actual harm to individual patients."[65]

The primary means to be undertaken against bad medicine was supervision. After a visit to a dispensary in Ulanga, the Governor of Tanganyika Territory himself asked "for more frequent and unhurried visiting of the tribal dispensaries by the medical staff."[66] But in a place like Ulanga the resources and knowledge for such supervision work were mostly missing.

In 'state medicine', issues relating to the state were as important as matters medical. The efficacy of a medical activity was computed in political terms as much as in medical ones.[67] Curative medicine in general was seen as very popular by the administration, and certainly in the 1940s it was popular all over the country and was continued even if supervision was difficult.[68] Injections were particularly in demand and came to play a central role in 'state medicine'. To many Africans, especially some of the chiefs, it seems to have been the absolute symbol of the power and commoditization of western medicine.[69] "*Dawa ya sindano ni ngumu sana*": the medicine of the syringe is great power to the dresser who knows how to make correct use of it, the District Commissioner wrote to the tribal dresser Edward Licheula at Ngombo dispensary.[70] One of the administrators in Tanganyika Territory to use the power of the syringe from early on was A.T. Culwick in Ulanga:

> "I find that the natives are not adverse to treatment. On the contrary the popular *'shindano'* ranks highly in the esteem of everybody, from the professional medicine-man downwards. The only difficulty is that treatment is not accessible to the majority of cases, who must walk

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Iliffe, *East African Doctors*, 1998, p. 45. Bruchhausen has a considerable discussion on his outlook on medical standards: Walter Bruchhausen, *Medizin zwischen den Welten*, 2006, p. 118 ff. For details on his medical policy in the post war period, see chapter 7.

[65] TNA 450/551/folio 6: A.H. Owen et al., *Circular letter no. 257. DSM, 14.11.1933*.

[66] TNA 450/551/folio 80: Director of Med Services Tanganyika Territory, *Letter 26.11.1938*. See also Patrick Thomas Malloy, *Holding by the Sindano*, 2003, p. 213.

[67] For the discussion of the medical side of the dispensary system see chapter 3. See chapter 7 for the way in which the 'medical' was opposed to the 'political' agenda in the 1950s.

[68] John Iliffe, *East African Doctors*, 1998, p. 48-50. Oswald Masebo, *Society, State and Infant Welfare*, 2010; Walter Bruchhausen, *Medizin zwischen den Welten*, 2006, pp. 108-111.

[69] The Ifakara Missionary nurse Sr. Arnolda 'punished' a man who had stolen her bicycle with an injection of nacl: Sylvia Sr. M. Buess, *Schweizer Missionare: Schwester M. Arnolda Kury, 1902-1962, Baldegg*, in Sendbote, 1991. The Swiss missionaries also reported that some people were prepared to work on a mission station for a full day in exchange for an injection: *Die Schweizer Kapuziner in Afrika. Jahresbericht 1937*, 1937, p. 26. Many historians have discussed the issue of injections. Susan Reynolds Whyte et al., *Social Lives of Medicines*, 2003; Markku Hokkanen, *Cultural History of Medicine(s)*, 2010; Luise White, *Speaking With Vampires*, 2000. The *shindano/sindano* is the Kiswahili word for syringe, compare with the title of the dissertation by Patrick Malloy Patrick Thomas Malloy, *Holding by the Sindano*, 2003. Memory of colonial doctors is remembering the power of the sindano: Gwynneth Latham et al., *Kilimanjaro Tales*, 1995, p. 159. J. Birney Dibble, *In this land of Eve*, 1965, p. 91. For an early example of chiefs pressing for African staff giving injections see TNA 13571/I: Native Authority Bukobwa et al., *Letter to District officer, Bukoba (Ref. No. D/2/2), Bukoba 15.01.1932*. For an example from Ulanga see: TNA 461 16/8 Vol I: Nkosi Kapungu et al., *Correspondence Nkosi Kapungu, Kilosa kwa Mpepo with DO Mahenge, 22.04.1947, 09.08.1947, 22.08.1947*. In 1951 the central government medical administration tried to stop dressers from giving injections, but did not prevail.TNA 61/ 351 Vol II: Tanganyika Territory District Commissioner Rufiji, *Letter to P.C. E.P., 27.06.1951*; TNA 450/1508/8: *Annual Report Eastern Medical Region, 1951*.

[70] TNA 461 16/8 Vol I: *Letter to DC Mahenge to Edward Licheula, Mahenge 18.03.1948*. Licheula had been asked to go to an injection training in 1947, see letter dated 01.04.1947 in the same file.

> in many miles to Kiberege [where a government staff dispenser was trained in giving injections ...] this raises questions of housing and food and makes treatment such a nuisance [....] if only we could make treatment more easily obtainable, we could, by taking advantage of the faith that obviously exists in the *'shindano'*, reduce the incidence of the disease [Yaws?] almost to vanishing point."[71]

The Medical Officer in Mahenge and Culwick agreed that the African Dispenser, Martin Msowaya/Msowoya, should be sent to train the dressers in the district in giving injections.[72] Vaccination was also part of preventive medicine. When it seemed that dressers were hardly working to capacity, the Medical Officer of Mahenge suggested that dressers "be trained as vaccinators and employ their spare time in visiting their respective areas."[73]

But here a cautious approach was necessary as the political factor of 'popularity' was brought into the calculation:

> "It occurs to me that the vaccination of all out-patients who attend the tribal dispensaries as a matter of course might tend to discourage attendance [...]. For this reason it might be as well to make the experiment of vaccinating at one dispensary only and observe the consequences."[74]

This trial was eventually implemented and proved popular in Kiberege.[75] Injection became a symbol of medicine and profession. In the 1940s dressers in colonial Tanganyika/Ulanga were extensively trained in the skills needed to give injections.[76] A Dar es Salaam District Officer offered a "clumsy" but very practical solution to the problems of grading tribal dressers "according to the usefulness [of a particular class of dresser] to the Native Authorities". The suggested criterion for the pay-scale (and their usefulness to Native Authorities) was whether they were capable of giving intravenous injections, capable of only giving BST intramuscular injections or not capable to give injections at all.[77] Dressers seem to have shared the perception that the capacity to give injections should also bring an entitlement to better pay.[78]

The comparatively large-scale attempt to train tribal dressers in the 1940s in Ulanga thus served the interests of the district administration as much as that of the chiefs and the dressers themselves because it made powerful medicine available to their subjects and to patients. African demands were therefore an important aspect of medical service provision and planning.

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[71] TNA 61/129G: A. T. Culwick, *Letter to P.C.E.P. Kiberege 18.02.1933*. On Culwick see especially chapter 4.
[72] TNA 61/129G: Claude Hollingworth Philips, *Letter MO Mahenge to DMSS. Mahenge 18.09.1933*; TNA 61/129G: A. T. Culwick, *Letter to P.C.E.P. Kiberege 18.02.1933*.The Director of Medical Services supported the suggestion: TNA 61/129G: R.R. Scott, *Letter DMSS to PC E.P. DSM 05.01.1934*.
[73] TNA 61/129G: Claude Hollingworth Philips, *Letter MO Mahenge to DMSS. Mahenge 21.10.1933*. Dressers were reported to vaccinate widely with injections without a medical officer's supervision prompting the mission doctor Schuster to ask about the scope of her authority to intervene (into state medical service provision) when she saw unacceptable use of injections: TNA 455/692/: Medical Missionary Committee, *Report of the Medical Missionary Committee*.
[74] TNA 61/129G: F.W. Brett, *Letter PC to DMSS. 298.12.1933*.
[75] TNA 61/129G folio 35: *Letter ADO Kiberege to PC EP. Kiberege 25.04.1934*; TNA 61/129G: R.R. Scott, *Letter DMSS to PC E.P. DSM 05.01.1934*; TNA 61/129G: R.R. Scott, *Letter DMSS to PC E.P. DSM 12.03.1934*.
[76] TNA 461 16/8: *"Tribal Dispensaries"*.
[77] TNA 61/682: District Commissioner Uzaramo Dar es Salaam, *Saving Telegram Re: Wages of N.A. Servant: Tribal dressers*.
[78] TNA 461 16/8: *"Tribal Dispensaries"*, folio 237 Letter from dessers in Sofi and Itete 221.206.1946.

## African Demand in Administrative Debate

A debate in the colonial administration in 1932 illustrates how the consumers were taken into account in debates about the health delivery system. The debate was most probably spurred by the Mission's interest in having equal resource in the competition for African patients.

In 1932 a missionary and member of the colonial 'parliament' (the Legislative Council for Tanganyika Territory ) suggested to the Finance Committee that the system of free treatment in government and Native Authority health institutions should be changed to a system of, in today's parlance, "cost sharing".[79] The member argued, that "the normal native places a far higher value on any medicines for which he has to pay, and, in fact, prefers to pay for them" because costlier medicine was believed to be more potent. Building on a well-established missionary discourse, the member was also under the impression that it was "morally better for the natives that they should pay."[80] The debate in the political (though not the medical) administration which this suggestion provoked highlights some of the central elements of colonial authority's views on health provision for Africans. It speaks about governance, the racial and social ordering of colonial society and medicine, and about the medical marketplace.

The Chief Secretary (CS) conducted a poll with District Officers (DO) and Provincial Commissioners (PC). The final conclusion at the end of the process was short – "imposition of fees is neither desirable nor practicable" and in 1938 it was even considered 'illegal' practice by the Mission.[81] But the opinions collected in the reports by the DOs make a telling story. Told to consult with chiefs and 'natives' in general, the DOs in the Eastern Province came up with a kaleidoscope of answers that reflected (the ideology behind) the political economy of social services.

The Commissioner of the Eastern Province, which included Mahenge, inferred that the power of a particular medicine did not result from the fact it was to be paid for. The power of medicine depended on the credibility of the knowledge the person dispensing medicine. It resulted from the fact " that [the Native] places a higher value on attention, treatment and dispensing by a European for which he can pay [...] They regard a bottle of medicine prescribed and made up by a European as more efficacious than [those which] are prescribed by an Asiatic and made up by an African."[82] The 'native' here in question hardly was the ordinary African

[79] I have not been able to access to the original question in the Assembly documentation. Patrick Thomas Malloy, *Holding by the Sindano*, 2003, p. 150.
[80] TNA 61/231: Tanganyika Territory chief Secretary to the Government et al., *Circular Letter No. 18 of 1932. DSM 01.03.1932*.
[81] Document dated 12.08.1932 in the file. The PC consensus was "emphatically negative": TNA 455/692/: Tanganyika Territory Director of Medical Services, *A report on a Meeting between Representatives of the Medical Departemtn of the Gvt in DSM and Representatives of Missionary Socieites working in Tanganyika [22.07.1938]*.
[82] TNA 61/231: F.W. Brett, *Letter PC E.P. in reply to Circular Letter No. 18 of 1932. DSM 01.03.1932. 02.06.1932*. 'Western' health commodities were consumed in complex ways. Timothy Burke, *Lifebuoy Men, Lux Women*, 1996, pp. 175-176; Susan Reynolds Whyte et al., *Social Lives of Medicines*, 2003, pp. 5, 16. For a long-durée history of African consumerism and the 'domestication' of imports see: Jeremy Prestholdt, *Domesticating the World*, 2007. There is an extensive

living in the very remote corners of Mahenge. But it was a perspective that came up strongly in the report from Dar es Salaam, where the Catholic mission dispensary in Msimbazi was located:

> "A very large number of natives prefer to go for treatment to Msimbazi Mission and pay for it largely because they are attended by a European and a European does the dispensing. They openly state, and here I am expressing the opinion of educated natives also, that they have more confidence in the medicine which they know is prepared by the European, and they have little confidence in medicine prepared by Native dispensers."[83]

It is evident that medical work was a broadly racialized at the time, and in urban areas it even contributed to expressions of class. For urban districts, the DOs found a willingness on the part of native elites to pay for first-class services with preferential treatment and a degree of segregation, both for in-patient as well as out-patient services.[84] Uneasiness about the racial ordering of colonial urban social services, which prioritized race over class, came through in these messages, especially in the statement by the Provincial Commissioner of the Eastern Province:

> "Many of the better class natives are deterred from going into Hospital by reason of the fact that they may find themselves accommodated in a bed cheek by jowl with an uneducated and primitive native whose habits and ideas of personal cleanliness leave much to be desired."[85]

This was not an entirely urban problem as we shall see shortly. In Kiberege and Ifakara, Indian traders in particular claimed better medical services, and would later profit from private hospital services.

But demand in the rural dispensaries was perceived quite differently. Here, colonial health services saw their role not in enabling class-differentiated conspicuous consumption but to deliver added value from colonial rule to the African population. Although historians and anthropologists have in the meantime pointed out the role of status strategies and social factors in medical consumption, colonial governance attempted to spread medicine evenly across rural society. And thus "the effectiveness of the whole medical system as related to the indigenous population," it was concluded, "depends upon free medical treatment".[86] From Kilosa the message was, that "Natives consider that they are quite entitled to receive free medicine from Tribal Dispensaries on the ground that it was bought with their tax money by the Native Treasury."[87]

One of the worries of the Chief Secretary had been the moral danger of pecuniary considerations.[88] This moral argument about the negative consequences of cash and

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argument about the power of commodities and the cultural remaking of 'things' in the Comaroff's work, see for their current take Jean Comaroff et al., *Twenty Years After Of Revelation and Revolution*, in Social Sciences and Missions, 2011, pp. 161.

[83] TNA 61/231: *Letter DO DSM in reply to Circular Letter No. 18 of 1932. DSM 01.03.1932. DSM 23.03.1932*. TNA 61/231: *Letter DO Kilosa in reply to Circular Letter No. 18 of 1932. DSM 01.03.1932. Kilosa 21.04.1932*.

[84] TNA 61/231: *Letter DO DSM in reply to Circular Letter No. 18 of 1932. DSM 01.03.1932. DSM 23.03.1932*; TNA 61/231: F.W. Brett, *Letter PC E.P. in reply to Circular Letter No. 18 of 1932. DSM 01.03.1932. 02.06.1932*.

[85] TNA 61/231: F.W. Brett, *Letter PC E.P. in reply to Circular Letter No. 18 of 1932. DSM 01.03.1932. 02.06.1932*.

[86] TNA 61/231: *Letter DO Rufiji in reply to Circular Letter No. 18 of 1932. DSM 01.03.1932. Utete 22.04.1932*.

[87] TNA 61/231: *Letter DO Kilosa in reply to Circular Letter No. 18 of 1932. DSM 01.03.1932. Kilosa 21.04.1932*. Note that Kilosa had one of the earliest hospitals for Africans. Wolfgang U. Eckart, *Medizin und Kolonialimperialismus*, 1997, p. 318.

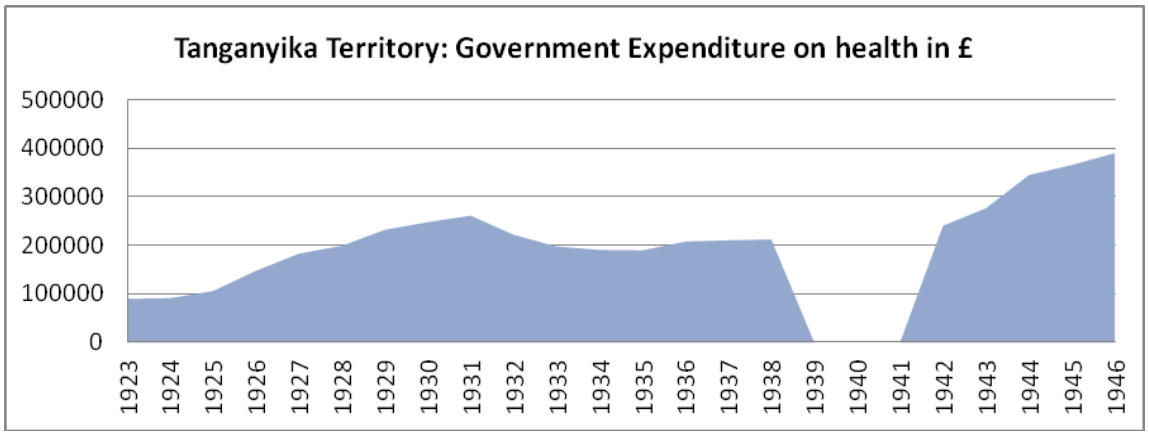
[88] TNA 61/231: Tanganyika Territory chief Secretary to the Government et al., *Circular Letter No. 18 of 1932. DSM 01.03.1932*.

commoditization was lost on the DOs with one exception: the DO in Morogoro instantly responded that he was against charging at dispensaries for fear of fraud [probably by the medical staff], while on the other hand there was "the danger that if everything is done for the native free of charge that he will get into a state of relying on the Government too much."[89] Here laid bare was the racist and paternalist colonial administrative conundrum which was to lend a bad taste to 'development': 'natives' were to be made responsible but could not, at the same time, be trusted to act in responsible ways. It reflects wariness about the transfer of the institutions of medicine without the transfer of an entire culture of 'civilization'.

## Preventive Medicine as Austerity-Measure

Such discussions about medical services were set within the context of an economic crisis that seriously limited all attempts at extending the curative medicine dispensary system. John Iliffe describes the period 1929-1945 as one of a "crisis of colonial society". A weak economy and repression rather than vision were the markers of this crisis.[90] The world economic crisis not only curtailed what little hope there could have been for metropolitan investment into African welfare systems – it also crushed the prices of global market products coming from Tanganyika, not least that of cotton, which was also produced in Ulanga.[91]

On the health system level, the economic crisis resulted in serious cuts in the medical administration (as we can see in the next graph), that make the 1930s look like a lost decade.[92]




**Adapted from Zucchelli, Appendix**

[89] TNA 61/231: T.M. Dawkins, *Letter DO Morogoro in reply to Circular Letter No. 18 of 1932. DSM 01.03.1932. Morogoro 10.03.1932*.
[90] John Iliffe, *Modern History of Tanganyika*, 1979, pp. 342-376.
[91] Walter Rodney, *How Europe underdeveloped Africa*, 1981 [1972], p. 158; Andrew Coulson, *Tanzania. A political economy*, 2013 [1982], pp. 48, 77.
[92] Severino Zucchelli, *Medical development in Tanganyika*, 1963, appendix. Meredeth Turshen, *Impact of Colonialism*, in International Journal of Health Services, 1977; D.E. Ferguson, *Politcal Economy of Health and Medicine*, 1980, pp. 332-333. also African Medical and Research Foundation et al., *Health Services of Tanganyika*, 1964, p. 9; Ann Beck, *Medicine, Tradition, and Development*, 1981, pp. 10-11.

The answer to the cutbacks was to push preventive medicine much more strongly. It "holds far greater promise", the Director of Medical and Sanitary Services commented in favor of preventive medicine when the Medical Department was re-organized in 1933.[93] The act mentioned preventive medicine and finances in a sequence:

> "No doubt, that the skill, time and money spent on the individual would, from the point of view of the Territory as a whole, be expended to much greater advantage on preventing disease. In this connection it must be remembered that the financial position of the Territory entirely prohibits the establishment of hospitals [...] to provide for more than a very small percentage of the population...."[94]

Prevention and public health were the core tasks of modern state medicine.[95] Faced with the duty to advance medical services in an environment of financial cut-backs, the Director of Medical Services saw prevention as "the improvement of the health of future generations of the population."[96] This stance regarding future generations created a promise based on a longer perspective on modernization - a perspective which came to be typical of Development thinking. This was not simply a cynical way for the state to evade its duties. The state's concentration on public health also reflected a social reformist agenda and left a deep imprint on future health policies.[97]

Thinking in terms of prevention and public health also opened the medical field to a series of new themes, like nutrition, which affected the population as a whole.

The verbal reinforcement of prevention-based health care did not reach Ulanga in terms of services in the period of the 1930s. Additionally, this talk of prevention was prevalent at a time when the expansion of dispensaries in Ulanga was practically halted. Small-scale services meant little expense. The central medical administration at that time spoke in a straightforward manner about the efficiency cuts needed in the sector of curative rural medicine:

> "Though much better value is obtained from the money spent on them, the posting of fully trained dressers in the same numbers as the old ones will lead to greater expenditure in that they will be able to treat a great variety of ailments and, in the aggregate, a larger number of cases. One way of dealing with this is to have half the number of dressers, or even less, give each of them a semi-skilled assistant who does not even have to be literate..."[98]

In the 1930s, the formation of a public health agenda as the content of state medicine went hand in hand with the halting of curative medicine. In the 1940s, however, as we will see in

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[93] TNA 450/551/folio 6: A.H. Owen et al., *Circular letter no. 257. DSM, 14.11.1933*.
[94] TNA 450/551: Legislative Council Tanganyika Territory, *Memorandum on the Reorganization of the Medical and Sanitation Department (Sessional Paper No. 6 of 1933)*, p. 104.
[95] Martin Lengwiler et al., *Historizität, Materialität und Hybridität von Wissenspraxen*, in Geschichte und Gesellschaft, 2008; Dorothy Porter, *Public Health*, 1993; Dorothy Porter, *Health Civilization and the the State*, 1999; Henry Wyldbore Rumsey, *Essays on state medicine*, 1856.
[96] TNA 450/551/folio 6: A.H. Owen et al., *Circular letter no. 257. DSM, 14.11.1933*. On public health in Tanzania see: Meredeth Turshen, *Political Ecology of Disease*, 1984; Beatrice Halii, *Colonial public health campaigns and local perceptions of illness*, 2007; R.R. Scott, *Public Health Services in Dar es Salaam in the Twenties*, in East African Medical Journal, 1963.
[97] Note that this was the moment when 'social medicine' took hold on a global scale. For example in the writing of the doyen of medical history, Henry Sigerist: Elizabeth Fee et al., *Making Medical History*, 1997.p. 153 Shula Marks, *Early Experiments*, in American Journal of Public Health, 1997; Howard Phillips, *Grassy Park Health Centre*, 2005. Lesley Doyal et al., *The political economy of health*, 1983 [1979], p. 16; David Piachaud, *Fabianism, Social policy and Colonialism*, 2010.
[98] TNA 61/129 vol I: Tanganyika Territory Direction of Medical Services, *Letter to PC E.P. DSM 15.04.1937*.

the next two chapters, sleeping sickness dispensaries would bring better curative services once again. For the final part of this chapter, we remain with the question of how government strategies functioned at the local level.

## The Local Politics of Health Service Allocation

The remainder of this chapter examines to what extent the spatial establishment of the rural health system and the provision of specific medical services was a result of political and administrative processes. The colonial state and the system of Indirect Rule produced specific territorial arrangements, but they also produced demands from local people for state medicine. From the early 1930s traders in Ifakara demanded better health care services and it was repeatedly debated within the administration but also in the public sphere whether more administrative and service functions should be delegated to Ifakara. These claims also highlight the position of Ifakara as a rural centre. In most parts of Ulanga, the location of dispensaries and the question of state control over 'Western' medicine was related to the potential of the dispensaries to foster the administrative legitimacy of the Native Authorities, as the first examples show. The debate in Ifakara was quite explicitly about the primacy of Ifakara over other places in the district and it touched on the issue of race.

### Low Ceilings for Native Authorities

Native Authorities allocated importance to medical services. It could happen that a dresser followed a transfer decreed by a chief and ended up in a place where another dresser had already been placed. In the actual documented event when this occurred, the dresser was sent back to his original post by the medical and political administration.[99] The difficulties of local politics can be seen in even more detail in Malinyi, a central place for the upper Kilombero valley which was eventually, in the late 1950s, to receive its own Protestant Mission Hospital. In 1940 a new Native Authority dispensary was built in Malinyi.[100] This dispensary was in proximity to a Mission Dispensary of the Berlin Mission which must have, due to the war, lost its missionary support base and its German staff.[101] The reports coming in from Malinyi were contradictory, but it seems that the population was very unhappy about the closure of the Mission dispensary:

> "[The] local community shows some concern at [the] proposed step since dressers have drugs, equipment and knowledge with which Native Authority Dressing station at Malinyi

[99] TNA 61/129G: A. T. Culwick, *Letter ADO Kiberege to MO Mahenge. 28.09.1933*. TNA 61/129G: Claude Hollingworth Philips, *Letter MO Mahenge to DMSS. Mahenge 18.09.1933*.
[100] TNA 461/27/1: Tanganyika Territory District Commissioner Ulanga et al., *Annual report for the year 1940 Kiberege Division, Ulanga District*.
[101] TNA 61/231H: *Letter Political, Kiberege to Provincer, DSM. 25.08.1941*.

> cannot compete. Grateful if you can devise some means keeping this dispensary open. Native Treasuries Kiberege poor and only able to afford limited medical assistance to people."[102]

The Director of Medical Services at first objected that "we should not allow these dressers, who are professionally unknown and unsupervised, to carry on at Kipingo [Mission dispensary]."[103] As it turns out from a later source, the 'dresser' in question, Hebedi Kisenene (or Kisumene) had only been trained on the job and, from the point of view of a Medical Officer, was not knowledgeable enough to take charge of a dispensary on his own.[104] But at the time of the debate, it seems that the administration was convinced of Kisenene's comparatively good qualifications (he was also charged with government work in controlling an outbreak of Cerebro Spinal Meningitis in 1941). Apart from the lack of supervision, the Director of Medical Services was also opposed to the support of the Kipingo Dispensary because the Mission Dispensary collected fees. Consequently, the District Officer was advised to close the Malinyi Mission Dispensary, to take a complete inventory and take all "dangerous drugs" to Kiberege.[105]

Somewhat later, the Director of Medical Services changed his mind and "the vox populi was heard."[106] Alas, the pro-Mission 'vox populi' and the Native Authority differed. When, to make way for the Mission Dispensary, the N.A. dispensary was to be closed, the Chiefs [were] "strongly opposed to the closure of their dressing station." The chiefs explicitly demanded, that "of the two, [the Mission dispensary in Kipingo] should be closed, i.e. it should remain closed."[107] It was, however, difficult enough for the Chief to make ends meet financially. A struggle for financial resources to keep staff in the dispensary added another layer to the conflict. In 1939 the District Officer had suggested already that the Native Treasury would pay for a training course for the dressers Hebedi Kisenene (or Kisumene) of the Berlin Mission dispensary. However, an up-grading of services was hardly sustainable "I am not certain that the Native Treasury will be able to employ the men on completion of the course [...] it seems a pity to let these two [dressers] go to seed at Kipingo."[108] The example shows the ceiling against which local actors hit their heads. The Chief and his advisors must have felt all the more frustrated that with the government support shifting to the Mission Dispensary, the Christians rather than the Native Authority would profit from the external support by the medical administration.[109] It points to the fact that by that time the focus of institution-building could switch from 'indirect rule' to

[102] TNA 61/231H: E.C. Baker, *Letter PC E.P. to Primed DSM. 12.12.1941*. The DO who originally reported this also stated that "To a layman, the dispensary appears unusually well equipped containing six cupboards of drugs and utensils (including what appear to be a microscope and a large sterilizer), in addition to three locked cupboards which presumably contain further drugs." TNA 61/231H: R. Bone, *Telegram to PC E.P. 01.12.1941*.
[103] TNA 61/231H: *Letter Political, Kiberege to Provincer, DSM. 25.08.1941*.
[104] TNA 61/231H: A.G. Mackay, *Letter to Dir. of Med. Services. Government Hospital Morogoro, 08.06.1942*.
[105] TNA 61/231H: E.C. Baker, *Telegram to DC Kiberege. 14.10.1941*.
[106] TNA 61/231H: E.C. Baker, *Note 25.06.1942*. This was supported by the Director of Medical Services TNA 61/231H: R.R. Scott, *Letter Dir. of Med.Services to Senior Medical Officer, Morogoro. DSM, 23.06.1942*.
[107] TNA 61/231H: R. Bone, *Telegram to PC E.P. 01.09.1942*. TNA 61/231H: Primed, *Letter to P.C. E.P. DSM. 24.12.1941*.
[108] TNA 61/231H: R. Bone, *Telegram to PC E.P.. Kiberege 23.09.1939*.
[109] The Director of Medical Services had at least signalled his willingness to help if Native Treasury funds would not suffice. TNA 61/231H: Primed, *Letter to P.C. E.P. DSM. 24.12.1941*. Although missionaries had to leave, the Church was still present in this area. Marcia Wright, *German Missions*, 1971, p.209.

'better medical service quality', which also meant that not the official state institutions, but institutions with intervening power were supported. As the next example shows, this did not mean that medical service quality had priority over 'state reasoning' in general. Rather, it testifies to a cultural-racist undercurrent in state-building which did not belief that an efficient biomedical system could be based on the Native Authorities and their financial leverage.

## A Government Dispensary for Kiberege

The Central government established its own health institutions in the administrative centres: in Mahenge and in the Kiberege area, offering the best quality modern health services apart from the Mission.

In the late 1920s Kiberege – about 35 kms from Ifakara, had become the district administrative post. Consequently, Kiberege was also made into the centre of a rural government health service system in the valley. Not far from Kilombero, another 5 or 6 miles further away from Ifakara, the Chonde labour camp was located. Labour camps were meant to oversee labour migration. The camp at Chonde was an up-to-date establishment. It consisted of a group of modern style buildings with cement floors and walls, zinc roofing and with a well-built deep latrine. From 1930, an African dresser was posted in Chonde in addition to the Kiberege dispensary staff who visited once a week.[110] The camp dispensary probably served the local population as well. From later (1940) data on another labour camp close to Ifakara, it becomes clear that more than 90 per cent of the patients treated at the labour camp dispensary were local residents. Local residents also used the dispensary quite regularly across the months, with a low in the first rain and planting season of November and December, while migrant workers made more seasonal use with peaks in August and November.[111] When, in the second half of the 1930s, the Kiberege dispensary fell into disrepair and Ifakara was promoted as the place where health services for the population were most needed, the colonial administration discussed moving services from Kiberege completely to the Chonde labour camp.[112]

The Kiberege dispensary itself offered better standard dispensary services delivered by a more trained staff than almost all of the other places in the larger region.[113] In mission parlance, the government health services in Kiberege would have been called a small hospital. But unlike Mahenge it never had a medical officer in charge, and for the government it was clearly an

[110] TNA 61/129G: A. T. Culwick, *Letter A.D.O. Kiberege to P.C.E.P. Kiberege 03.11.1933*; TNA 61/231: A.H. Owen, *Report DMSS to Chief Sec. on visit to Mahenge, Kiberege and Kilosa. December 1932 [stamped PC E.P. 06.12.1932]*; TNA 61/129G folio 19: Claude Hollingworth Philips, *Ifakara R.C. Mission Hospital and Dispensary / Kiberge Government Dispensary / Chonde Labour Camp*.

[111] Numbers from: TNA 61/231H: R. Bone, *Letter to Rooke-Johnston. Kiberege 01.07.1941*.

[112] TNA 61/231H: Director of Med Services Tanganyika Territory, *Letter to Chief Sec. DSM 29.07.1939*; TNA 61/68H: B.A. Rice, *Letter to Dir. of Public Works [exact date?]*; TNA 61/231H: M.Y., *[minute by the Governor on Kiberege Government Dispensary]*. In the 1950s Chonde camp was still in use: TNA 461/27/1: *Kilosa and Ulanga District Annual Report for the Year 1955.[Attachement] Section 1 Staff*. and in the 1960s it became part of one of the earliest villagization schemes of the independent government: Jamie Monson, *Africa's Freedom Railway*, 2009, p. 76. Eckhard Baum, *Land Use in the Kilombero Valley*, 1968, pp 44ff. See also: A.D. Beck, *Kilombero Valley*, in East African Geographical Review, 1964.

[113] TNA 61/231: A.H. Owen, *Report DMSS to Chief Sec. on visit to Mahenge, Kiberege and Kilosa. December 1932 [stamped PC E.P. 06.12.1932]*.

institution at the dispensary level. Within that category, health care at Kiberege was 'excellent' in the eyes of the new Director of Medical Services who went on a tour into the district in 1933:

> "Excellent work is being done at the station dispensary where an average of 23 new patients per day were seen in August and 21 per day for the first five days in September under a new Dispenser. A ward of 8 beds has been erected for the accommodation of patients from a distance who are unfit to return to their homes, but this was not occupied at the time of my visit."[114]

## 'Ifakara Condemned': the medical marginalization of a trade centre

Ifakara on the other hand was a weak spot in government health service provision. At least three times before 1945, Ifakara was "condemned by the medical authorities" (according to the colonial administrator A.T. Culwick). The first time was in 1929 when Ifakara was turned down as the seat of the colonial administration because of objections by the Medical Department against Ifakara for reasons of the 'insalubrious' climate at Ifakara.[115] It is an irony of the colonial era that this decision in favour of the health of the administrative staff prevented a large number of people living in this 'unhealthy' area from having easy access to health care. The second time Ifakara was 'condemned' by the Medical Department was in the period 1932-1935. Plans to move the administrative centre were stopped yet again in the course of a prolonged discussion about the insalubrity of Ifakara, and Kiberege was confirmed as the administrative post for half of Ulanga. The third time was in 1944, when the Medical Officer again looked into the matter of moving administration to Ifakara and concluded: "Taking all these facts into consideration, it is obvious that it would be extremely dangerous to station European personnel together with their ancillary staff in Ifakara itself."[116]

These decisions were not taken lightly and they testify to an extensive preoccupation of the colonial state about the correct location of administration. Unlike Kiberege, Ifakara was gazetted as a "Minor Settlement" in 1932.[117] The minor settlement was defined as the area enclosed by a circle of 800 yards radius having its centre at the Post office".[118] In 1932 the Director of Medical Services used the following words to describe the situation at Ifakara:

> "The business centre [of the Kilombero valley] is undoubtedly Ifakara and a Government hospital should, I consider, be established there as soon as possible. The Mission sister has enough work amongst their converts and has not the time to attend the medical needs of the Asiatic and general native population of this area. I understand that the Mission would welcome a Government hospital. Ifakara is unhealthy and [...] I am submitting a separate memorandum containing proposals for the building of an out-patient department with a small ward at Ifakara which could be put in charge of a [Sub Assistant Surgeon]. This officer could also supervise the Dispenser at Kiberege during the greater part of the year."[119]

[114] TNA 450/439: R.R. Scott, *Letter Dir. of MSS to Chief Sec. no place given 16.09.1933*.
[115] TNA 61/68H: A. T. Culwick, *Letter to PC E.P. Mahenge 23.03.1944*.
[116] TNA 61/68H: ?? Wilson, *Report sent to DMS. 04.04.1944*.
[117] In Government Notice 208 of 1932. In Ulanga, apart from Ifakara only Mahenge was designated a minor settlement. TNA *District Book, District Office Mahenge, No.1/section [name erased]*, Sheet on Ifakara, inserted by C.T. Culwick 13.12.1932.
[118] TNA *District Book, District Office Mahenge, No.1/section [name erased]*, same.
[119] TNA 61/231: A.H. Owen, *Report DMSS to Chief Sec. on visit to Mahenge, Kiberege and Kilosa. December 1932 [stamped PC E.P. 06.12.1932]*.

This suggestion to make Ifakara the medical centre for the Kilombero valley was related to the attempts to move the administrative post to Ifakara. The Provincial Commissioner now believed it was "doubtful whether Kiberege is healthier than Ifakara."[120] The situation in Kiberege was assessed in 1933 and in 1935. A.T. Culwick and his wife wanted to move from Kiberege, where they had encountered serious health problems, to Ifakara, stating that "the German Medical Officers considered Kiberege to be the unhealthiest place in this area."[121] It was, however, advised by the medical specialists that Kiberege's health situation was on no better than that of Ifakara, and this could be ameliorated by moving the post upwards on the slopes of the mountain range, an option which was not really available for Ifakara.[122] For the Government, the promise this made for the health of the officers tipped the scales in favour of Kiberege and, on 16 October1935, the Chief Secretary approved the transfer of the HQ of the Mahenge District to Kiberege, the District being renamed 'Ulanga'.[123]

As a consequence, nothing was done to improve health care for the people in the minor settlement of Ifakara, although there were, subsequently, repeated demands for the provision of health services there. In 1933, 27 (Indian) "Merchants and other Non-Natives of Ifakara" petitioned the Director of Medical Services to make better medical provision at Ifakara.[124] The immediate reason for the demand was that even though they had undertaken "every effort" to save the lives of women members of their community, their experience with the available health facilities, including those available at the Mission dispensary of Sr. Arnolda, had proved these to be utterly inadequate. The signatories to the petition recalled that they had registered the same demands in 1932 at the market of Ifakara. Obviously, the Director of Medical Services did not come up with the idea of establishing a hospital in Ifakara all on his own. The petitioners listed reasons why more attention needed to be paid to medical matters in Ifakara. They described it as a

> "good populated place both of Natives and Non-Natives [...] There are 15-20 shops permanently and nearby all of the Indian merchants residing here are with families and children. It has been surrounded with many villages where Indian merchants are doing their business [... but it is connected only with] roads [...] too bad at least six months in every year [....]. In view of the above we hope to see a Doctor in a very near future."[125]

The District Commissioner's reply was extremely short. Acknowledging receipt of the petition he stated: "conditions [...] are known to Government, but at present the financial

[120] TNA 450/439: *Letter Chief Sec. to Dir. of Med and San Services. DSM 28.01.1932*.
[121] TNA 450/439: A. T. Culwick, *Letter A.D.O to Medical Officer Mahenge. Kiberege 02.03.1933*.
[122] TNA 450/439: Z.A.? Brett, *Letter Prov. Comm. EP to Dir of Med and San Services. DSM 11.03.1933*. TNA 450/439: (Dr.) Sanderson, *Ifakara*. TNA 61/231: F.W. Brett, *Letter PC E.P. to ADO Kiberege. 18.03.1935*. TNA 450/653: *Extract from D.M.S.'s letter no 439775 dated 16.09.1935 to C.S. at Paragraph 16*.
[123] TNA 450/439: G.J.? Partridge, *letter form Chief Sec to Prov. Comm. E.P. DSM 27.01.1936*.
[124] TNA 61/231: Merchants of Ifakara et al., *Petition not dated to PC E.P. Re: Medical Assistance [recieved 15.05.1933]*. The District Boook registered the following non-native 'trading centres': TNA *District Book, District Office Mahenge, No.1/section trading centres*.
[125] TNA 61/231: Merchants of Ifakara et al., *Petition not dated to PC E.P. Re: Medical Assistance [recieved 15.05.1933]*.

position does not permit the appointment of a Medical Officer and the building of his quarters and a dispensary."[126]

In 1935, a small step was made to upgrade medical services in Ifakara. The Director of Medical Services of Tanganyika Territory, R.R. Scott, visited Ifakara, and probably in response to the solicitations of A.T. Culwick, he convinced the Ifakara Chiefs to join in a campaign to popularize the treatment of hookworm. The Director promised to send a 'travelling dresser' each week to combat the effects of the "*dudu mbaya sana"* (the very bad bug) and he also enlisted the help of the Catholic Mission. The Dresser and Mission Nurse together were to identify those who suffered from the disease and to bring them for obligatory treatment. This campaign proved popular in a series of places in the region.[127] But it was obviously intended for the "natives".

To the Ifakara merchants, this was clearly inadequate to fill the gap in their needs. Their arguments in the petition of 1932-33 had staked a clear-cut political claim. In 1936 und 1937, they raised the matter again. ”When I was in Ifakara the other day," wrote A. T. Culwick,

> "The Indian Association brought up once more the question of the lack of medical facilities in that village. For reasons, which I believe they explained to you on your visit, they consider the Mission hospital inadequate, and allege that several deaths could have been prevented had there been a sub-Assistant Surgeon on the spot. I explained to them that it was quite impossible for Government to build a hospital in Ifakara, because amongst other reasons the recent survey has shown that within the next 10 to 15 years Ifakara will be cut off from the north by a broad band of swamp, due to the Lumemo River changing its course.[128] I urged the Indians to make more use of the dispensary at Kiberege [...]. They raised objection, however, that at present there is nowhere in Kiberege where an Indian patient can stay. I therefore propose that a small house of mud, poles and grass should be built near the hospital [i.e. the dispensary at Kiberege], and should be reserved for the use of Indian patients."[129]

Culwick’s suggestion spurred a debate inside the administration. The Provincial Commissioner noted his qualms on Culwick's filed letter:

> "Good as the African Dispenser at Kiberege undoubtedly is, I doubt whether the Ifakara Indians will go 21 miles for treatment to him. Also they are, I think, more likely to criticize Government than to appreciate the rough shelter proposed as a ward for them.”[130]

Another administrator supported this view and suggested, that the "Indians [...] should be encouraged to go to the Mission, and not to Kiberege.”[131] The Director, who had seen the situation in Ifakara in earlier years with his own eyes, agreed with this position and turned down the idea of state-sponsored separate treatment for Indian merchants:

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[126] TNA 61/231: F.W. Brett, *Letter to Mr. Lalji Somji, Merchant, Ifakara. 27.05.1933*.
[127] *Afrika-Post [Rubrik]*, in Missionsbote der Schweizer Kapuziner in Afrika, 1935; TNA 450/653 & 450/56: A. T. Culwick, *Extract from a personal letter from the A.D.O. i/c Kiberege to Dr. Scott, 11.09.1935*; TNA 450/56: A. T. Culwick, *Extract form a person letter from A.T.Culwick dated 22.09.1935 to Dr. Scott*; TNA 450/56: A. T. Culwick, *Letter to the Dir. of Medical Services. Kiberege 15.11.1935*. Hookworm was a 'popular' theme at the time. The mission dispensary in Msimbazi counted up to 70 daily consultations for hookworm: *Hakenwurm*, in Missionsbote der Schweizer Kapuziner in Afrika, 1936.
[128] TNA 450/653: A. T. Culwick, *Letter to Dir of MS. Kiberege 27.03.1936*, handwritten note by A.T. Culwick, dated 24.011941 [sic]: "this has since been prevented by bending " [difficult to decipher].
[129] TNA 450/653: A. T. Culwick, *Letter to Dir of MS. Kiberege 27.03.1936*.
[130] TNA 450/653: A. T. Culwick, *Letter to Dir of MS. Kiberege 27.03.1936*, note by PC dated 07.04.1936.
[131] TNA 450/653: A. T. Culwick, *Letter to Dir of MS. Kiberege 27.03.1936*, note by N.N. in the file re Culwick's letter.

> "Yes, the mission runs a good show at Ifakara. If the Indians insist on coming to Kiberege for treatment they can erect their own rest house for which we accept no responsibility."[132]

Another statement in the discussion, however, is revealing about the chasm between the health care system for Africans and that for 'Indians', noting that

> "The Indians at Ifakara should be encouraged to go to the mission hospital there; for the African Dispenser has had a limited medical training which was intended to fit him to deal with the common diseases found amongst Africans, but not to be a satisfactory medical attendant for Indians."[133]

At this point in time, matters had taken a couple of wrong turns. The merchants had never asked to be admitted to Kiberege, on the contrary, but it was now offered to them again with a note of condescension. All the while, the medical voice of the 'Indian' Sub-Assistant Surgeon in charge of the hospital in Mahenge (and of medical supervision in the District for that matter) seems to have been heard neither by the administration nor by the merchants. Loaded with a different perspective on medicine and on race relations, the Sub-Assistant Surgeon had noted that the medical knowledge of the mission nurses and their training "does not much exceed that of the Tribal Dressers […] if Tribal Dressers are trained, they should turn out as efficient."[134]

It might be that the Sub-Assistant Surgeon had a word with the Ifakara merchants: a mere 18 months later, when the merchant community once again challenged the existing situation in which the Government provided health services for 'natives' only, and forced the Indians to go to the Mission. They confronted the Provincial Commissioner on his tour of the Ulanga District with a request "that a Sub-Assistant Surgeon be posted to Ifakara".[135] The Director of Medical Services stated plainly that "there are many other stations which would have a prior claim".[136] This did not settle the issue. The matter was now raised in the Legislative Council of Tanganyika Territory. Again Government covered itself with the mission services.[137]

## Blockage in the Government Sector as Result

The answer by the Government testifies that the open question of Ifakara versus Kiberege as an administrative post only served to reinforce a situation of unproductive stalemate for the development of health services in Ulanga. The two doctors mentioned, the husband and wife team of the Drs. Gabathuler, were mission doctors who had just arrived and did not yet even have a hospital to work from. When they eventually were given charge of the

[132] TNA 450/653: A. T. Culwick, *Letter to Dir of MS. Kiberege 27.03.1936*, note by DMSS in the file re Culwick's letter.
[133] TNA 450/653: Frank Noble, *Letter to D.O. Kiberege. DSM 19.04.1936*.
[134] TNA 61/129G folio 38ff: *Report [by SAS Mahenge] on Inspection of Medical Out-Stations. Mahenge and Kiberege Districts [07.01.1934]*.
[135] TNA 450/653: *Letter PC E.P. to Dir of MS. DMS 08.10.1937*.
[136] TNA 450/653: *Letter for Dir of MS to P.C.E.P. DMS 11.10.1937*.
[137] Question by "Honourable D. K. Patel". While it was politically still an open question to which degree the missions were to be enlisted in medical services TNA 450/439: *Letter to Dir. of MS. The Medical Office, Kilosa 01.07.1939*. For a broader discussion see chapter 7. TNA 450/439: Tanganyika Territory Legislative Council, *Question: Medical Facilities in the Kiberege-Ifakara area*.

government hospital in Mahenge, the Sub-Assistant-Surgeon was withdrawn from the post.[138] The situation highlights the low ceiling of social services offered at the time – even to those 'non-natives' who made up the financial elite section of the population.

Kiberege had two dressers assisted by a travelling hospital orderly. But the medical infrastructure in Kiberege was poor and becoming worse. Although in 1938 Kiberege was still the training station for dressers and a sort of medical sub-centre the buildings were left to decay.[139] The dispensary building was attacked by white ants and was considered "unsuitable, [it] has no floor, grass roof and mud brick wall. [...] If there is to be a dispensary and dressing station at Kiberege this building requires replacement."[140] When the Governor himself went on a tour through the district, he was not amused with what he saw as representative of the medical services of the British Mandate in Kiberege: "I found the Government Dispensary at Kiberege in a most unsatisfactory condition when I inspected it on July 6th [1939]."[141] This visit triggered some quick decisions to renovate the dispensary. Following the Governor's rather explicit orders, things were reorganized in Kiberege. The medical department invested £50 to renovate the dispensary in Kiberege. A new burnt-brick dispensary was built and storage was reorganized.[142]

The Governor's political interest and his determination to protect at least the image of his administration under the British mandate had furthered the cause of Kiberege. On the other hand, no developments occurred in Ifakara, where the demand had been so vociferous. In 1941, complaints were heard once again in Dar es Salaam about the health care provisions in Ifakara. In a letter to the editor of the English paper, Tanganyika Standard, "K. Truth", obviously a member of the Ifakara Indian trading community, who chose to speak for all the people of Ifakara, wrote:

> "Sir [...] I want to lay down these few lines before Government. [...] I am [an] English subject by birth and I was educated at Ifakara and two other high schools and my home is Ifakara. It is [a] most sad thing to see that our Government is throwing us away. The reason of saying so is because there is no larger minor settlement in whole Ulanga District than Ifakara. [...] the taxpayers of Ifakara area are 3'000. Government has thrown such population without any sort, and built a Boma at Kiberege which is absolutely bush place and its people cannot reach even a quarter of Ifakara. [...] There are two hospitals at Ifakara, one for the Mission and the other for N.A. and that for the Mission wants fees still there are many poor people who cannot afford to pay fees for their daily attendances, and that of N.A. is not a well equipped dispensary. I think there are only 10 bottles and dressings. Beside that the dresser is not a well trained man to deal with many men [...]. Some time sick people who have failed to be treated by N.A. dispensaries in upper Kilombero and who can afford to pay the Mission they

[138] Chapter 6 discussed this story in detail.
[139] TNA 461 16/8 Vol I: G.W.S. Conan-Davies et al., *Letter to Hospital Assistant, Kichangani. 12.11.1945*.
[140] TNA 61/68H: B.A. Rice, *Letter to Dir. of Public Works [exact date?]*.
[141] Note attached to: TNA 61/231H: M.Y., *[minute by the Governor on Kiberege Government Dispensary]*.
[142] TNA 61/231H: Director of Med Services Tanganyika Territory, *Letter to Chief Sec. DSM 29.07.1939*. TNA 450/551/folio 80: Director of Med Services Tanganyika Territory, *Letter 26.11.1938*. TNA 61/231H: A. T. Culwick, *Letter to PC E.P.. Kiberege 23.09.1939*. TNA 61/231H: F. Longland, *Letter PC E.P. to DO Kiberege. 01.08.1939*. TNA 61/129H: F. Longland, *Letter PC E.P. to DO Kiberege. 20.10.1939*.

> come to Ifakara by canoes, [...]. Officer who built Boma at Kiberege did great mistake without thinking this matter properly."[143]

The matter was routinely shelved by the administration: "In the circumstances I do not feel justified in advising an extension of Government medical services to include Ifakara at the present time", the Medical administration noted.[144]

Two years later the "vexed question of the Boma for Ulanga District" surfaced again.[145] The name of Ifakara was again proposed as a promising place with roughly 40 per cent of the total population of the Kiberege Division. "There seems to be an idea that the importance of Ifakara will wane after the war, and that the export of rice will decline but, if that happens, we shall have failed lamentably in our administration of Ulanga district."[146]

The District Officer's arguments must be seen in relation to administrative ideas about economic development in Ulanga. However, voices in favor of small holdings and self-sufficiency gained currency in the mid-1930s.[147] A.T. Culwick, in particular, saw agricultural production by the African peasant as an economic priority. He was, unlike other administrators in Ulanga, supportive of agricultural production for the local market.[148] Ifakara, however, stood for trade and transport beyond the district.[149]

This also touched the question of the localisation of the administration:

> "Our duty here is primarily to the native, and I therefore consider that the headquarters should be within easy reach of as many centres of native production as possible, so that its staff can give the maximum time to them and to the social services we are striving to establish, a condition fulfilled neither by Ifakara nor Kiberege."[150]

Culwick therefore proposed to move the headquarters again to Mahenge[151], but the Provincial Commissioner was strictly against it.[152] The idea that Ifakara was to be washed away by the Lumemo River to him was as a "prophesy. Ifakara will be a bottleneck for many years to come if not forever."[153] In the end, Ifakara acquired a government rest-camp, so that visiting administrative staff could lodge comfortably enough. Mahenge was re-made into the main administrative centre of the District, and the government dispensary in Kiberege was abandoned.[154]

These changes in administrative geography did not result in a fast and effective extension of health care services in Ifakara. Things moved only in slow and small steps. In 1944, an African

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[143] K. Truth, *Letter to the editor, Kilosa 13.01.1941*, Tanganyika Standard, 23.01.1941.
[144] TNA 61/231H: R.R. Scott, *Letter Dir. of Med.Services to Chief Sec.: "Hospital Ifakara". DSM, 29.01.1941*.
[145] TNA 61/68H: J. Rooke Johnston, *Letter to PC E.P. Kiberege 15.03.1943*; TNA 61/68H: *Letter DO Kiberege to Mr. Baker ((PCEP?)). Kiberege 13.08.1942*.
[146] TNA 61/68H: *Letter probably by PC E.P to Chief Secretary. 28.04.1944*; TNA 61/68H: A. T. Culwick, *Letter to PC E.P. Mahenge 23.03.1944*. See also: TNA 61/68H: A. T. Culwick, *Letter to Wilson [MO of Health]. Mahenge 13.03.1944*.
[147] Jamie Monson, *Rice and Cotton*, 1995, p. 281, she bases her argument on J. Giblin; James Giblin, *Peasant Self-Sufficience*, 1990.
[148] Jamie Monson, *Canoe-Building under Colonialism*, 1996.
[149] Lorne Larson, *History of Mahenge*, 1976, pp. 289-311, 234-237.
[150] TNA 61/68H: A. T. Culwick, *Letter to PC E.P. Mahenge 23.03.1944*.
[151] TNA 61/68H: A. T. Culwick, *Letter to PC E.P. Mahenge 23.03.1944*.
[152] TNA 61/68H: A. T. Culwick, *Letter to PC E.P. Mahenge 23.03.1944*. Note on document
[153] TNA 61/68H: Political Kiberege, *Saving Telegram to PC E.P. Kiberege 05.04.1944*.
[154] TNA 61/68H: *Letter PC E.P. to DC Mahenge. 13.06.1944*.

District Sanitary Inspector, Mfaume Jinisha had been "temporarily posted at Ifakara to illustrate hygienic methods to the inhabitants."[155] In 1945 the Government started to build a dispensary in Ifakara town, slightly off the major thoroughfare. The Mission was to build it, but in August 1946 it was still not completed. The idea was to exchange staff between Kiberege and Ifakara, sending the better trained hospital assistant to Ifakara. But it seems that eventually both Ifakara and Kiberege lost, because the Director of Medical services transferred the hospital assistant away from Kiberege and out of the District altogether.[156]

In 1947, the debate in Ifakara once again produced multi-faceted activities. In January that year, the chief in Ifakara, *Nkozi* Hassani Njohole, took the initiative. The dispensary was now completed but was staffed only by a dresser, Aloisi Mgonera. *Nkozi* Njohole was ready to open the dispensary and wanted to keep Mgonera as a nurse but he wanted to have a better trained "Indian Dresser" or one of the young men who had "studied medicine better".[157] From the small documentation available it seems that there might have been claims from better trained Africans who lobbied to get such a post in Ifakara.[158] The District Officer promised to take the matter into his hands, and even the Provincial Commissioner soon subscribed to Njohole's agenda of getting better trained staff.[159] But this position was still a far cry from what the Ifakara population claimed as their entitlement to medical services provision in Ifakara.[160] When these demands continued, all government undertook was to send a better trained tribal dresser, Stephano Mwalindege, in May 1948. Eventually, Government transferred a hospital assistant from Mchangani (across the river on the road to Mahenge) to Ifakara.[161]

## Conclusion

This chapter has looked at how medicine provided an axis along which the colonial state developed its rural set-up in the 1920s. The debate about the geographical location of institutions raises important issues about the development of health services in Ulanga. It shows the degree to which health service delivery was shaped by administrative politics, and thus how health care delivery was restricted by the mechanics of a colonial administration based on

[155] TNA 450/1230/2: Saidi Rupia, *Kiberege Dispensary. Concise Annual Report for 1944 [03.01.1944]*.
[156] TNA 461 16/8 Vol I: Fr. Jerome *Letter to DC Mahenge. Ifakara 07.11.1945*; TNA 461 16/8 Vol I: G.W.S. Conan-Davies et al., *Letter to Father Superior R.C. Mission Ifakara. 27.10.1945*; TNA 461 16/19: Tanganyika Territory District Officer Mahenge, *Letter to District Commissioner E.P. 19.08.1946*; TNA 461 16/19: Tanganyika Territory Provincial Commissioner E.P., *Letter to DC Ulanga. 14.09.1946*.
[157] TNA 461 16/8 Vol I: Hassani Njohole, *Letter to DC Mahenge. Ifakara 10.01.1947*. The letter is in Kiswahili, the quotes are my translation.
[158] TNA 461 16/8 Vol I: Pius Erhardt *Letter to DC Mahenge. Ifakara 11.01.1947*.
[159] TNA 450/653: Tanganyika Territory Provincial Commissioner E.P., *Letter to Dir. of Med.Serv to 16.08.1947*. This document also describes the dispensary which was erected at a cost of £350.
[160] TNA 450/653: Indian Association Ifakara et al., *Letter to Dir. of Med.Serv. DSM, District Comm. Mahenge and Provincial Comm. E.P. DSM. Ifakara, Ulanga District 09.06.1947*.
[161] TNA 461 16/8 Vol I: *Letter DC to Dresser Stephano Mwalindege, Malinyi. Mahenge 30.04.1948*; TNA 450/653: I Laufer, *Letter Medical Officer to Dir of Med. Serv.. Mahenge, 10.07.1948*; TNA 450/653: I Laufer, *Letter Medical Officer to Distr. Comm. Mahenge. Mahenge 31.07.1948*. See chapter 7 for more information on demands for health services in Ifakara in the late 1940s.

'indirect rule' and limited investment. This was so even as it aimed to create, with moderate means, rudimentary "Western-style" state institutions in the rural periphery. At the same time, chiefs and Indian merchants pressed for more medical services and argued for the extension and institutionalization of state medicine.

Investment in health services did not arise out of an allocation of funds decided through any sort of democratic process, nor was there any prioritization of general health benefits. The governmental logic at that time seemed consider the establishment of the machineries of power as almost an end in itself. But this also brought about the introduction of a new purpose of government which carried with it the biopolitical issues constitutive to the modern state with a "pastoral" agenda. Anti-famine measures were an early expression of the need to sustain the population. These pastoral power practices turned Africans into subjects of a state which nevertheless felt only limited responsibility towards its 'sheep'.

Those at the receiving end of welfare were often deemed responsible for their misery. This was hardly a new feature in a European cultural and moral discourse on welfare. In the colonial situation, the image of the "obdurate" Africans, who "prefer to die in the district they know and where they have lived for years, rather than go to seek pastures new and unknown"[162] established a baseline for a discourse of "help for self-help". This particular colonial articulation of the 'invention of the social' forced Africans into a set of activities which effaced autonomous African ideas of social progress, as Hubertus Büschel has shown.[163] The Native Authority Dispensary was based on 'Western' medicine. Containing a grain of solidarity, 'help for self-help' nevertheless established a discourse of a moral economy of Development which often mitigated the negative impact of imperial self-interest of the benefactor and disguised the true position of the beneficiary.[164] In addition, the ceilings for service provision were very low.

Still, this was the period when the state started to consider the rural as a field for social governance. A popular argument brought forward by historians is that peripheral areas were considered mainly as a kind of African reserve, the extraction of profits from migrant labour was key and investment into the rural was limited.[165]

The rural areas are often conceptualized to be marginal, even unconquered by the state.[166] This idea of the disconnected 'rural space' as opposed to the 'urban space' where social change occurs has been rightly criticized, as it risks the effacement of history made from the

[162] TNA 450/34/3 G.D. Popplewell, *Mkasu Leper Report [probably April 1929]*. The statement was made in the context of the leper camp at Mkasu which was assisted by the mission and taken over in 1934. TNA 450/34/3 Medical Officer Mahenge, *Extract from the letter no 1/1/3(30 of 07.01.1930 to Dir of Med Services*; TNA 450/34/3 Gerard Fässler, *Letter to Medical and Sanitary Dept. Kwiro 31.03.1934*; TNA Acc.450/HE/178/16: Gerard Fässler, *Letter to Direct. of MS, Mahenge 05.10.1937*.

[163] Hubertus Büschel, *Eine Brücke am Mount Meru*, 2009; Arturo Escobar, *Encountering Development*, 1995, pp. 22-23.

[164] 'Help for self-help' seems to have a smaller potential to acknowledge the "mutual dependence" expressed by act of 'solidarity'. René Holenstein, *Was kümmert uns die Dritte Welt*, 1998, p. 12. But discourses of 'solidarity' tend to hide inequalities and produce images of the other (as partner), too. Marcel Dreier, *kämpfendes afrika, 2002*, 2002.

[165] Randall M. Packard, *healty reserve*, in American Anthropologist, 1989.

[166] Goran Hyden, *Beyond Ujamaa*, 1980.

margins and not just diffused from the 'centre'.[167] It also underestimates how much the state in Africa was characterized by the creation of a mode of domination that constructed specific rural institutions, including the 'idea' of the subject, as Mahmood Mamdani has argued. In the 1920s, new institutions were devised specifically for the rural areas which were meant to govern and service rural populations, serving as the local state.[168] This was, however, also shaped the mode of production and the building of infrastructure. The argument by the District Officer, Culwick, against a concentration of higher standard of health care services in Ifakara at the end of the 1930s extolled the idea of rural development based on peasant production in the village. The establishment of dispensaries in the countryside did not end the "disparity between medical service in town and countryside" which a former administrative officer in Ulanga recalled from his tenure in the 1930s.[169] Rather, it marked the beginning of a path of 'Development' that acknowledged or rather defined large parts of Africa as being 'rural'. The notion of the rural at that time provided no space for a hospital in Ifakara and no support to a Native Authority which lacked the means to pay for better trained medical staff. The limitations that were placed on development by the definition of rurality either delayed or blocked development, and the welfare institutions put controls on a dynamic process in the name of rural governance. Under their influence, 'modernity' acquired a Janus-faced character.

[167] William Beinart, *Beyond Homelands*, in South African Historical Journal, 2012.
[168] Mahmood Mamdani, *Citizen and Subject*, 1996, pp. 18, 20, 77, 294-296.
[169] David F. Clyde, *Tanzania*, 1980, p. 114 question from E.E. Sabben-Clare.

# Chapter 3 The Dispensary in Ulanga

This chapter looks at the kind of medicine practiced in the dispensaries, the medical institutions that were the harbingers of medical modernization, in Ulanga in the 1920s and 1930s, and gives a very local perspective on the "age of the tribal dresser".[1] The network of dispensaries established in the late 1920s and the 1930s brought more than political forms of state presence to Ulanga. It also offered specific forms of medical goods and practices to the people. A small set of dressings, drugs, and the equipment to prepare and administer them were given to dressers. These new figures in the medical marketplace gained new forms of medical expertise and were the contact point of 'modern medicine' and the people in Ulanga. As the new concepts, tools and medicines were absorbed (or rejected) and reshaped in local practice, dispensary medicine added new ways to heal the social and individual body and broadened epistemes of healing, disease and medicine.[2]

The health care system described in this chapter was run almost exclusively by Africans. Even in mission services it was often the African dresser or dispenser who translated in the course of treatment or did much of the medical work him- or herself.[3] This 'indigenization' of the health services was a strategy of government and of the missions who felt that African middles could serve as mediators and bring progress from within the 'African race'.[4] For the mission, it was important that African women in particular learnt the female work of hygiene and care for the family.[5] For a number of reasons addressed in chapter 2, the 'biomedical quality' of medical

[1] John Iliffe, *East African Doctors*, 1998, p. 34.
[2] Walter Bruchhausen, *Medical Pluralism*, 2010, p. 104.
[3] *Die Schweizer Kapuziner in Afrika. Jahresbericht 1930*, 1930, p. 16: Pater Werner reports on his assistant Pauli. In the Tabora leprosy camp, the sisters visited only once a week for injections; the daily medical work was done by at least two dressers. *Die Schweizer Kapuziner in Afrika. Jahresbericht 1940*, 1940, p. 18.
[4] A. R. Paterson, *The provision of medical and sanitary services for natives in rural Africa*, in Transactions of the Royal Society of Tropical Medicine and Hygiene, 1928. The presentation was followed by a discussion in which McKenzie, a doctor working for the Colonial Medical service in Tanganyika who was, much later, to become the acting Medical Director of the Territory, challenged the speaker. In Tanganyika, held Mckenzie, African medical staff, like the Native Rural Sanitary Inspectors, had proven to be "extremely efficient when acting on their own initiative."
[5] In the eyes of the missions, the 'native Christian dresser' was this figure, and was meant to "promote a new sense for welfare of the race." TNA 455/692/: F. Kroeber, *Medical Missions and native life*. On the need to train the mothers of the future chiefs, see: P. Hieronymus Schildknecht, *Mädchenerziehung in Ostafrika*, in Seraphisches Weltapostolat des Hl. Franz v.

services of these African Native Authority health services often remained low throughout the 1930s and well into the 1940s.[6] In 1945 the Mahenge-Ulanga District Commissioner had to take responsibility for medical matters in the District because of the absence of a Medical Officer, and he visited the remoter dispensaries like those at Ngombo, Utengule or Kilosa kwa Mpepo.

> "The supply of drugs and equipment were pathetically small, just two or three bottles [...] I should like to try [...] to improve supplies and perhaps the efficiency of the dressers, who seemed to be good character. [ ... ] The dressers told me how long they had been trained, under Mr. Morton, Hospital Assistant, [most of them 2 years or more]. As these dressers were mostly ex-standard IV boys the periods do not seem very long in which to become proficient in the use of a microscope. [...] I could not help wondering if these dressers could handle the profusion of drugs and equipment to the best advantage especially as they are unsupervised and untaught by a medical officer and have no books of reference. [...] I did glance through several out patients registers [... and] could find hardly a case in which a patient had had more than one injection of the course for Bilharzia, which is, I believe, rather a waste of a drug."[7]

In the 1940s, even in the face of all the training, medical equipment was still so insufficient as to make efficient practice in strictly biomedical terms almost impossible. This chapter looks at the history of the dispensary as an institution in order to evoke an image of what the 'dispensary' must have meant to Africans living in Ulanga and how it reflected biomedicine: 'modern medicine' was not a comprehensive system of healing or a consistent body of healing practices. Dispensaries delivered a rather small set of services. Medical institutions could not aspire to form a comprehensive welfare system: as welfare institutions they were fragile, sometimes more of a facade than a shelter. Nevertheless, these practices installed a health care system that was conceptualized as an 'indigenous' service and indeed did take on a very local character in the way it configured 'modern' medicine.

The first dispensaries were opened in Ulanga with the beginning of the Territory-wide dispensary system. The reports are not too reliable, but according to my calculations there were at least two to four additions every year between 1927 and 1931. Then, in 1932, much in line with the development of the dispensary sector across the Eastern Province and Tanganyika Territory in general, stagnation set in.

Compared to the size of the district, the dispersed settlement patterns and the fact that travel was undertaken on foot and, in some places, in dug-out canoes, the dispensaries with their basic medical services were far from reach for most people.

Almost all the dispensaries had been built in the early late 1920s and early 1930s and now some of the older ones already urgently needed rebuilding or at least major reconstruction. Most were three-roomed 'native type huts' of about 6x5 meters which consisted of an office, an

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Assisi, 1932. and how this was done in Ifakara: P. Aquilin Engelberger, *Bauen in Afrika*, in Seraphisches Weltapostolat des Hl. Franz v. Assisi, 1932, pp. 204.

[6] For discussions on this issue within the Medical Administration, see: TNA 13571/III: R.R. Scott, *Tribal Dressers for Southern Province trained at Tanga, 06.09.1940*.

[7] TNA 461 16/8 Vol I: G.W.S. Conan-Davies et al., *Letter to Dir. of Med Serv. 12.11.1945*.

out-patient treating room and the living room for the dresser. There was no room for in-patients to stay at the dispensary. Not all of dispensaries had shelves to store the boxes with the drugs and tables which were standard equipment.[8]

There were not many roads in the area, but many of the dispensaries were lined along the main roads – or what have come to constitute the main roads today. There were not many specialized mission medical institutions either. They were particularly missing in the southern parts, where the Ngindo group mostly resided. In Ifakara, already then easily spotted on the map as the place where the two major roads coming from the south and the Kilombero valley merged towards Kilosa, there was only a mission dispensary, but no government establishment in the 1920s (and 1930s).

The location on the roads had much to do with the routines of administration described in chapter 2. The reason given for the placement of a limited number of dispensaries at easily accessible spots was that it allowed a wide coverage of population. The question we might raise is about the quality of the cover. Some kind of promise lay in the word 'medicine' but the content of this medicine was only marginally defined. Already at the end of the 1920s the District Officer of Mahenge felt that the newly established dresser system was a success, but that closer supervision was needed:

> „The dispensaries have been a success generally speaking but like all schemes where natives are left in charge for periods long or short, according to accessibility, it has been found that as close a supervision as possible [...and] absolutely essential, if abuses are not to creep in. [...] For this reason the extension of the system suggested for 1929/30 will be made dependent on the condition that the localities chosen shall be easily inspected."[9]

Given the limited training offered to the staff at the dispensaries, it was hardly a dresser's fault if he worked according to his own rationale. Besides, with tours by Medical Officers being very rare, competent medical supervision was hardly available. The reports on the travels of the Medical Officer and later the Sub Assistant Surgeon from Mahenge testify to an administrative activity concerned mostly with taking stock of what services existed on the ground.[10]

## Medicine at the Dispensary

One of the issues that came up in the course of supervision was the low attendance rates at the dressing stations. On a tour in 1932, the Director of Medical Services had seen a dispensary system that rolled out little in the form of treatments:

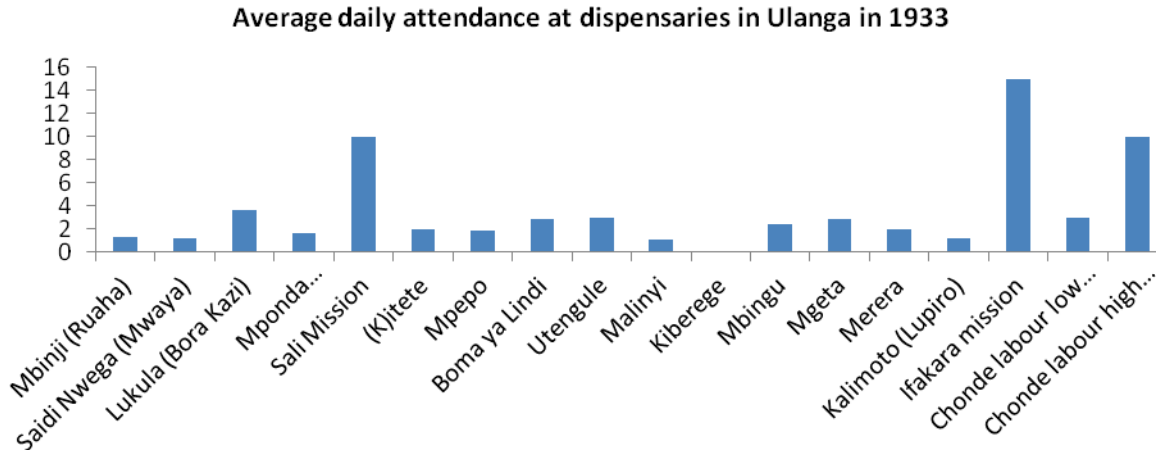
> "Monthly returns by the tribal dresser [...] show that very few natives attend and the majority of patients appear to be suffering from minor ailments such as scabies. The attendance for diseases such as malaria and yaws are negligible."[11]

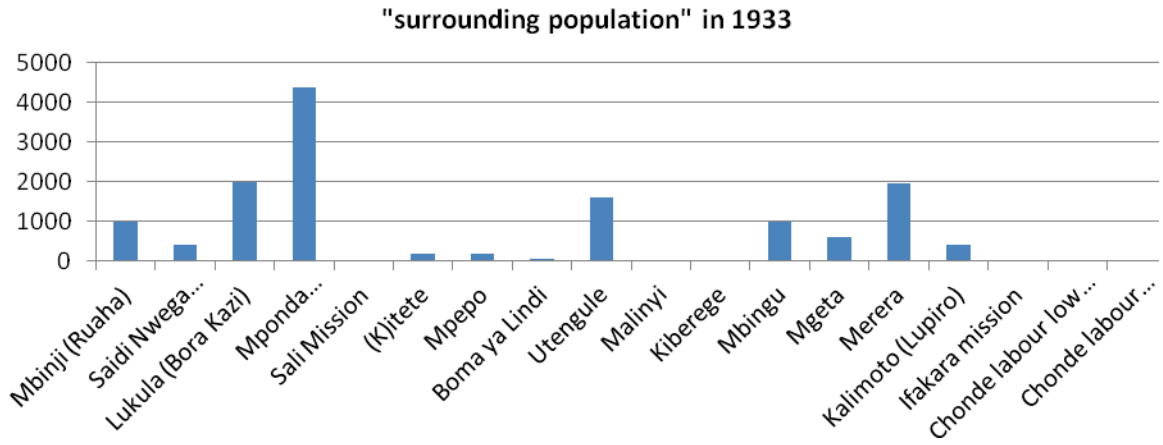
[8] TNA 61/129G: *[file] Village Dispensaries Mahenge*.
[9] TNA 13571/I: *Letter P.C. Mahenge Province to Chief Sect. TT, Mahenge 17.11.1928*.
[10] TNA 61/129G: *[file] Village Dispensaries Mahenge*.
[11] TNA 61/231: A.H. Owen, *Report DMSS to Chief Sec. on visit to Mahenge, Kiberege and Kilosa. December 1932 [stamped PC E.P. 06.12.1932]*.

The Assistant District Officers' impression was more favourable, but reports in 1933 confirmed the low attendance rates. It was even considered that the dressers, who had to care for but one patient per day could be used for other duties:

> "The average daily attendance is so small that the dresser cannot be occupied for more than a few minutes daily. You should consider whether there is not some other work which may be usefully performed by them without interference with their duties as Tribal Dressers."[12]

### *Graphs: Attendances and population*[13]




What can be grasped from these tables is that the Mission medical services and the labour camp that was run to control migrant labourers had comparably high attendance rates. In the case of Ifakara, the numbers given in the government sources are much lower than those given by the Mission, which calculated 50-70 rather than 16 consultations per day.[14] Additionally there is a treatment availability factor that has to be taken into account at that time: the Mission gave injections before the Native Authority dispensaries did so.

[12] TNA 61/129G: F.W. Brett, *Letter PC to ADO Kiberege. 29.09.1933*.
[13] Compiled from: TNA 61/129G: *[file] Village Dispensaries Mahenge*.
[14] PAL 1057.J. Ifakara / Briefe: H. Schildknecht: Hieronymus Schildknecht, *Letter Ifakara 27.02.1932*.

We can only speculate what made attendance numbers at the N.A. dispensaries so low. Notably, it remains unclear if the numbers collected by the medical department staff were correct. Supervision reports attested that all dressers kept registers neatly.[15] But the Provincial Commissioner believed that underreporting must have been the reason for low numbers – and comparatively the high consumption of drugs. The District officer, A.T. Culwick wanted to keep costs low and treatment numbers high:

> ”The figures that the Medical Officer has given for the average daily attendance merely confirms doubts I have had for some time as to whether the dressing stations are worth the expense. In spite of the small attendances they use up large quantities of expensive drugs, and are consequently costly institutions to run...“[16]

He clarified in another letter:

> “My meaning was that many of the tribal dressers are in my opinion wasteful in their use of certain drugs, notably iodine, jodoform, various ointments, linens etc. I have attempted to teach them economy ...”[17]

The Provincial Commissioner however defended the system:

> „It is unlikely that the drugs would be used for any other purpose than for the patients, so that the two facts that large quantities of drugs are being used, while the attendances appear to be small, would point to the fact that the attendance, register is not being properly kept."[18]

Although it must remain in the realm of historical speculation, it is attractive for the cultural historian to reflect on the situation presented in these contradictory views, because they most probably point to the lived practice of dispensary medicine at the time. What was the kind of 'medical' work that made use of these drugs but could not produce the expected patient numbers? To start with the most obvious: how was the drug thought of as an agent? While the western 'dispensary' science measured and counted in milligrams, this was not a common practice in the handling of drugs in an Ulangan healer’s tradition. The power of a drug stemmed from its capacity to establish a connection with healing powers or to fend off of malignant powers, rather than work as a biochemical reagent in itself. It is therefore very unlikely that a frugal way of dispensing only small doses was popular in any way with the users who would hope to receive a larger measure of medicine.[19]

A dresser also knew that some of his patients in a dispersed settlement had to come a long way, and he might have been more open to give medicine for treatment at home much more than the mission nurses who were nervous about the use of the medication they dispensed and the way it was combined with other, local treatment. Even if drugs were used as the manuals prescribed, would a dresser have had the scales to correctly measure them?

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[15] Reports on individual dispensaries. Still the PC was convinced that untidy registering was the explanation. TNA 61/129G: P.C.E.P., *Letter to A.D.O. Kiberege, 02.11.1933*.
[16] TNA 61/129G: A. T. Culwick, *Letter A.D.O. to P.C.E.P. Kiberege 11.10.1933*.
[17] TNA 61/129G folio 24: A. T. Culwick, *Letter A.D.O. Kiberege to P.C.E.P. Kiberege 16.11.1933*.
[18] TNA 61/129G: P.C.E.P., *Letter to A.D.O. Kiberege, 02.11.1933*.
[19] Maia Green, *Medicines and Embodiment*, in The Journal of the Royal Anthropological Institute, 1996. Susan Reynolds Whyte et al., *Social Lives of Medicines*, 2003. A. T. Culwick et al., *Ubena of the Rivers*, 1935, chapter v: Religion and chapter xvii: Medicine. For a collection of missionary sources see: Sidonius Schoenaker, *Hintergründe*, 1965. See the introduction to this thesis for a discussion of different medical cultures and practices. On East African concepts of healing see: Charles M. Good, *Ethnomedical Systems*, 1987. Stacey Langwick, *Bodies, Politics and African Healing*, 2011.

Also, any healer was connected to the world of the patient through a social relationship. Dispensary medicine was lived out in these social relationships and the status of a dresser relative to his clients. Would a dresser have the authority to decide on correct dosage all by himself? There was always a degree of agency of the patient in the way drugs were administered.[20] In the context of dispensary medicine it is most likely that the dresser's *dawa* would be applied plentifully and in creative ways. When even the missionaries felt compelled to offer injections of natrium chloride or to adapt to alternative ways of applying medicine, it is all the more likely that dressers developed their own ways of producing medicines that were meaningful in the context.

Beyond the question of quantity, there is the question of 'disease' and its social reality. We may conjecture that 'wastefulness' also represents the chasm between reportable diseases and treatable diseases. Why should a powerful reagent not also be tried by the dresser for a disease that was linked to 'witchcraft' in colonial medical terms, i.e. in a context not accredited by biomedicine? It is difficult to imagine how a dresser would report the use of medicine in such treatment in an environment that was unfriendly towards African concepts of disease in general, and towards witchcraft in particular, and which negated African agency in the production of medical knowledge outside the traditional herbal pharmacopeia.[21] It was one thing for the colonial bureaucrat to decide in theory how drugs were meant to be used but it was a completely different thing to bring these drugs into action. To work with a patient meant taking risks and responsibility for someone else's body and social being; and it equally meant being held accountable for these medical interventions.[22] If Missionaries felt the competition with healers, why should dressers working with dispensary medicine not also feel the dynamics of a medical marketplace? They were in competition with other healers, who sometimes actively worked to deter people from going to the dispensaries.

The District officers and medical administrators were aware of the problem of trust and confidence. Residency - that the dresser was tenured on to his post – was a necessity for rural health to work successfully in a situation where trust had to be established.[23] That the missionary dispensaries had such great attendance numbers is not necessarily a proof of

[20] Steven Feierman, *Change in African therapeutic systems*, in Social Science & Medicine. Part B: Medical Anthropology, 1979. Medical Anthropology has produced many insights on Therapy Management Groups: John M. Janzen, *Therapy Management: Concept, Reality, Process*, in Medical Anthropology Quarterly, 1987. Helen Sweet, *The Patient, the Porter, the Probationer and the Preacher: Changing Perspectives of the Mission Hospital in rural KwaZulu Natal* (paper presented at the Imagining and Practising Imperial and Colonial Medicine, 1870-1960, 2008); Roy Porter, *The Patient's View*, in Theory and Society, 1985.

[21] For examples on the use of 'modern' medicine in anti-witchcraft practice in the 1950s in Ulanga see Patrick Harries et al., *Medizin und Magie*, 2012. An interesting discussion on the missionary view on African pharmacopeia and how they worked in Walter Bruchhausen, *Medizin zwischen den Welten*, 2006, pp. 162-153.

[22] The colonial debate about 'witchcraft' and 'witchcraft cleansing' explains these problems well: Lorne Larson, *Problems in the study of witchcraft eradiction movements in Southern Tanzania*, in Ufahamu, 1976; DAK & PA Dreier Lorne Larson, *Witchcraft eradiction [manuscript]*. Maia Green, *Witchraft Suppression Practices*, in Comparative Studies in Society and History, 1997. Simeon Mesaki, *Witchcraft and Witch-Killings in Tanzania: Paradox and Dilemma*, 1993. TNA District Book, District Office Mahenge, No.1 / Language Notes: Eric Reid, *Some Notes on Witchcraft among the Wapogoro*.

[23] TNA 13571/I: *Letter Dir. of Medical and Sanitary Services to Chief Secretary 16.05.1933*.

confidence in 'biomedicine'. It probably had to do with the power the institution held over the Christian community, and with the way in which Christian patients probably lived their spiritual life mediated through Christian *dawa*.[24]

'Western' medicine was thus a complex new product of the dispensary. The Medical Officer from Mahenge believed that Africans identified 'Western medicine' with the dispensary from the early 1930s. He read this from the fact that his professional attendance "did not seem to raise the slightest enthusiasm" with the people he met on his tour through the district. Used to being accosted for help or drugs wherever he had toured in his former district, the doctor attributed the disinterest he experienced in Ulanga to "the fact that they realize that treatment is available at the Dispensaries. This is all to the good..."[25]

This explanation is not entirely convincing. It might be true in the case of some Christians, who would turn to a mission dispensary. But the general disinterest in the doctor reflected other factors that limited interest and trust in 'dispensary medicine' more broadly. Quite apart from the caution towards a government official, Ulanga people probably hardly shared the confidence of the doctor in his own healing powers. They had not, after all, witnessed their effectiveness in their villages, which is to say, outside military campaigns, hospitals or within the very limited boundaries of medical treatment available at the dispensary. But the dispensary with its medical offers located closer to everyday life was hardly in a position to offer great medical success and it was not much used either.

Scattered settlement structure had an influence on patient's attendance rates, but it is difficult to assess its impact. When one compares the daily attendances with the "surrounding population" noted in the government files, we find huge discrepancies. Mponda, for example, had very small attendance numbers compared to its population. However, these numbers are extremely difficult to analyse. It could be that the perception of (political) geography between the administration and the supposed users differed extremely, or that the ways in which dispensary medicine was sought was more complicated than just geographical vicinity. One aspect was also access to local treatment. In the government discourse of that time, this all fell under the category of "competition":

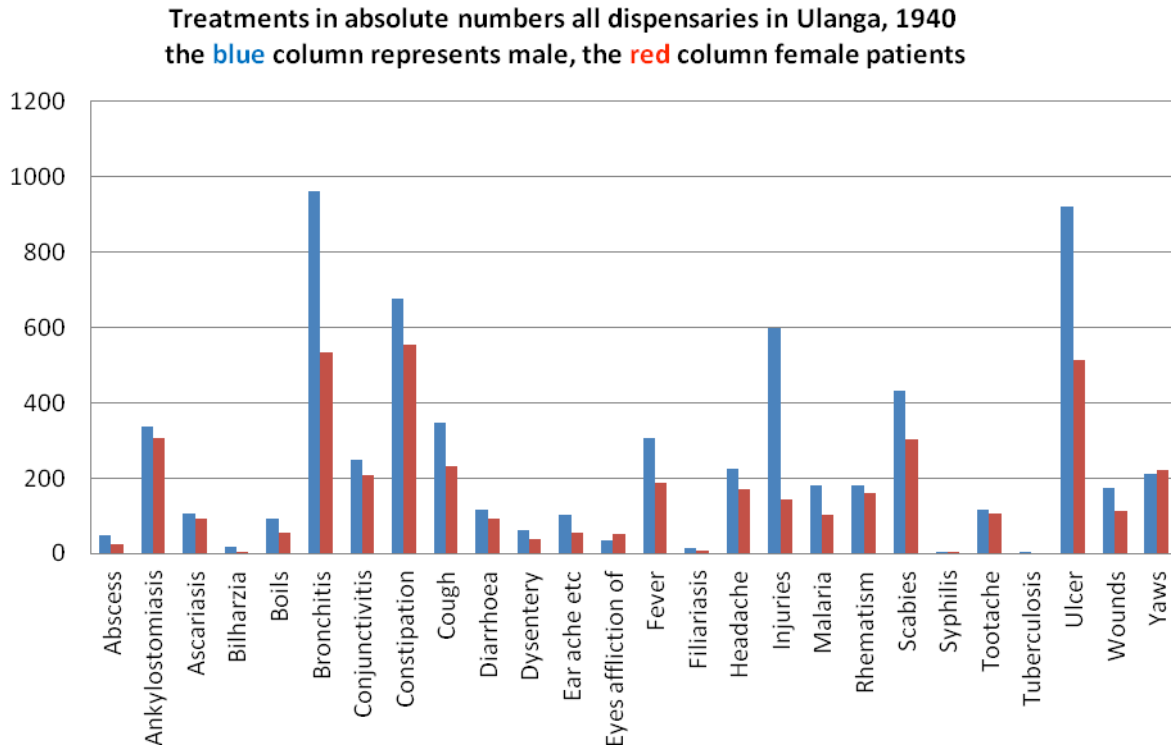
> "There are several reasons for the very small attendance at the dressing stations, but probably the chief one is the competition of the native medicine men, many of whom appear to possess herbal remedies of considerable value. The general feeling amongst the native population is that their *'waganga'* are all they require for most maladies, and that the *'serkali'* [Government] should concentrate on those diseases which the *'waganga'* cannot, or find it

[24] Maia Green, *Priest, Witches and Power*, 2003, p. 73.
[25] TNA 61/129G: Claude Hollingworth Philips, *Letter MO Mahenge to DMSS. Mahenge 18.09.1933*. Philips was an experienced doctor who had served in Tanganyika Territory since 1920, mostly in the Arusha area Anna Crozier, *Practising Colonial Medicine*, 2007, list with MO's .

> difficult, to cure, e.g. syphilis, yaws, leprosy, various skin diseases afflictions of the eyes such as iritis, etc."[26]

Still, a wide enough range of medical problems were treated in the dispensaries.

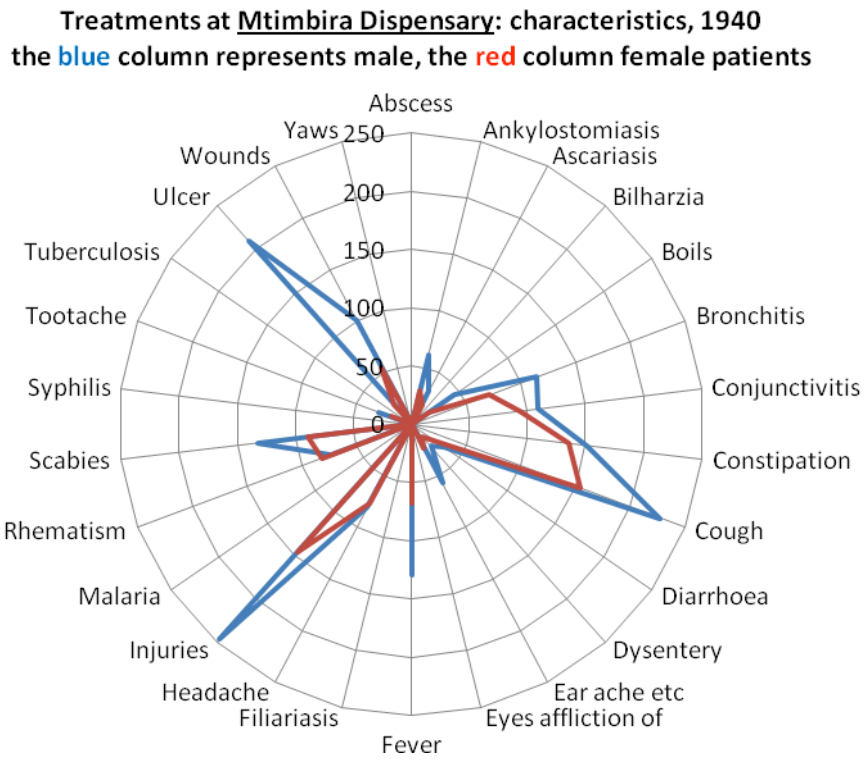
***Graph: Medical treatments[27]***




It is fascinating to see how varied the kinds of treatments which the dispensaries offered at the time were, at least from the porous data we have. Mtimbira was the place with the largest number of treatments and the graph below can give an impression of the medical problems encountered at the dispensary system level in about 1940 (blue represents male and red female patient numbers).

[26] TNA 61/129G folio 24: A. T. Culwick, *Letter A.D.O. Kiberege to P.C.E.P. Kiberege 16.11.1933*. Both A.T. and G.M. Culwick were interested in native medicine. See their A. T. Culwick et al., *156. Treatment of Fits by the Wambunga*, in Man, 1934; A. T. Culwick et al., *Ubena of the Rivers*, 1935.

[27] Based on TNA 461 16/8 Vol I: *Analysis of Diseases treated in Mahenge Division Tribal Dispensaries 1940*.




But not all kinds of 'Western' medical treatments were available everywhere and no spider graph reflecting the statistic in a dispensary looks like that of any other. There can only be one conclusion, namely, that dispensary medicine was locally specialized. This specialization can hardly be a reflection of local epidemiological disease patterns and loads. Rather, it is the expression of institutional specialization, depending on dressers' abilities and preferences in diagnosis and treatment. How else could it be explained that Malaria is absent from the chart in Mtimbira (note, however, that "Fever" is present, but with only about half the number of Injuries)?[28] In the dispensary at Ruaha, in the South of Mahenge, it looks as if the dresser at the time only treated Bronchitis, Ulcers and Constipation. These three diseases were the major medical problems reported for the female patients at the dispensaries overall. Ulcers, Bronchitis and Injuries were the largest categories reported for males.

In the dispensary at Luhanyando, a bit further south of Ruaha, Yaws was by far the most commonly treated medical problem in 1940. Yaws treatment was given by injection.[29] But the injection needle seems to have been absent in Mtimbira where, it is worth noting, more medical treatments were registered than anywhere else. At least in absolute numbers, the injection needle was not the criterion for the utilization of medical services. Neither did any other of the dispensaries report the treatment of Yaws. Injuries were commonly treated at all dispensaries,

[28] Malaria is an interesting case. In Southern Tanzania 'Malaria' was often seen as fever, and the affliction going by the name of degedege overlaps considerably with the biomedical understanding of Malaria. C. Comoro et al., *Local Understanding*, in Acta Tropica, 2003; Stacey A. Langwick, *Devils, Parasites, and Fierce Needles*, in Science Technology Human Values, 2007; Susanne Hausmann Muela, *Community Understanding of Malaria*, 2000.

[29] Marc H. Dawson, *Anti-Yaws Campaings*, in The International Journal of African Historical Studies, 1987. There is reason to be cautious about Yaws treatment numbers. For an example of a Sub Assistant Surgeon forging numbers to please the Medical Director see Gwynneth Latham et al., *Kilimanjaro Tales*, 1995, p. 33.

but they were almost exclusively reported for male patients. While the gender discrepancy in injury numbers seems to be explainable by male work and leisure activities, bronchitis was largely a male issue at Luhanyando too. This fact does not lend itself to easy explanation, much less so because in Ruaha bronchitis was very commonly diagnosed for female patients at the dispensary. Bronchitis was hardly ever diagnosed at all in Mwaya, a dispensary in the same section of Ulanga. In Mwaya, female patients made up the large majority of hookworm patients. This could be read as a sign that female patients were pushed to use the dispensary for this particular problem which was so much in the focus of government and chiefly campaigns – and thus a sign that state medicine did not reach only males.

Gender imbalance in attendance numbers was quite striking, although I came upon only one single commentary on such gender inequalities. It was made by an experienced medical officer stationed in Mahenge. When he travelled in the area for the first time, he noticed a "poor attendance especially amongst women, it is however difficult to judge whether they [sic] indicate healthy population or indifference to medical facilities."[30] He reported only one set of numbers though, Ruaha and Mwaya, where between 70 and 90 per cent of the reported users were male.

Gender relations had changed towards a more equitable situation in 1940. Still, there was no balance: services for male patients still dominated with between 55 and 65 per cent of the totals in Ruaha and Mwaya. The overall picture from the dispensaries in the Mahenge section of the district only shows one dispensary (in Chera) with a small majority of female use – but this was a dispensary with very low attendance numbers. Two-thirds of the dispensaries had female usage rates at less than 40 per cent.

## Dressers

Dispensary medicine was practiced by African health workers called 'dressers'. This professional designation was still used in the 1960s. But it is difficult to follow the dressers in the archives available. There is one file, entitled "Tribal Dispensaries" in the Tanzanian National Archives that helps to understand dressers in Ulanga from their own writing.[31] These men were (almost all) literate in Kiswahili and the letters in the file offer a fragmented view on their interaction with the district administration, and with the chiefs under whom they served. The file largely covers the 1940s when "sleeping sickness dispensaries" offered general dispensary services of a slightly better quality alongside the Native Administration dispensaries offered in the 1930s. The medley of themes in this file speaks of the rather unregulated organization of the

[30] TNA 61/129G: Claude Hollingworth Philips, *Itinerary of Inspection of Tribal Dispensaries at Mbinji and Saidi Nwega, Mahenge District, 25.08.1933*.
[31] TNA 461 16/8: *"Tribal Dispensaries"*.

'tribal' medical services, which depended in matters of staffing, training, drug provision, and even building, on the brokerage of the District Commissioner. This was particularly the case in the years when there was no Medical Officer available for the medical administration of the district. As there is so far no trace of the District Medical Officer's papers, the file is the best and only body of documentation we have. From this file and other instances in the sources I have sought to at least glimpse the careers of these 'tribal dressers'. The African medical staff was not an undifferentiated group; for there were clear hierarchies based on training. What I attempt to do here is draw up an anecdotal overview of what constituted the training and function of 'tribal dressers'.

Dressers often signed their letters as *Dresser*, but there were other terms used in local parlance. The Kiswahili *Bwana Mganga*, Mister Healer, was sometimes used by the administration when they addressed chiefs on the matter of dressers, maybe in order to make the building of dispensaries appear more attractive to the Native Authorities.[32] From Ubena, A.T. Culwick provided the local name for dressers used exclusively for those trained in biomedicine as *mwilwana* (sing).[33] The professional label 'dresser' was still very common to denote male African medical staff with a basic medical training in the 1960s and, today, older people are still familiar with the nomenclature.[34]

Dressers worked for Government medical services, for the Native Authorities, or for missions.[35] There was, nonetheless, great fluidity between these employers and it would be difficult to say if a particular individual was exclusively a mission dresser. I have compiled from largely government sources a list of more than 70 dressers names, including two women, who practiced in Ulanga in the 1930s and 1940s. In this list, dressers working for the missions are certainly underrepresented, as they were hardly ever mentioned, even less so by name in the mission sources I accessed.[36] In 1935, the Capuchin Mission reported the employment of six white sisters, four African dressers and six women, including one female African assistant midwife, working in the medical services on their mission stations in the Dar es Salaam Vicariate.[37] The Catholic mission in Southern Tanganyika had its own training system, based on the hospital in Ndanda and the female missionary doctor Thekla Stinnesbeck.[38] Stinnesbeck's

[32] TNA 461 16/8 Vol I: D.O. Mahenge, *Letter DC Mahenge to Mtua Maji, Native Court, Chera. Mahenge 22.10.1940.*
[33] A. T. Culwick et al., *Ubena of the Rivers*, 1935, p. 116.
[34] Edgar Widmer, *Geschichte der schweizerischen ärztlichen Mission in Afrika*, 1963, p. 11-12; ASML R1T1S1O4: Rudolf Lehnhoff, *Final Report and Considerations (SFH, Tanzania, 01.08.1983-30.09.1986)*, pp. 12-13.
[35] Sometimes government also paid dressers working in mission services, when they worked in the context of government subsidies medical work, for example in the leprosy settlement in Tabora. *Ein Stündchen bei den Aussätzigen.*, NZZ, Nr. 281, 17.10.1931. TNA 61/231G: Director of Med Services Tanganyika Territory, *Letter to E. Maranta. 26.07.1939*.
[36] Note that I have in most cases not accessed the general documentation kept by the priests. Dressers at these stations might have been named there, but they were not mentioned in published reports in mission journals, medical reports etc.
[37] Sr. Bernadette Gabler, *Die Sorge um unsere kranken schwarzen Bürder und Schwestern im Apostol.Vikariat Daressalaam (Ostafrika)*, in Missionsärztliche Caritas, 1935. This includes stations in the Dar es Salaam area and Kipatimu.
[38] Thecla Stinnesbeck, *Krankenbericht 1938 vom Hospital Ndanda, Aussätzigenheim und 7 Aussenstationen*, in Missionsärztliche Caritas, 1939. Walter Bruchhausen, *Medizin zwischen den Welten*, 2006, pp. 453 following.

textbook on clinical laboratory methods was in high demand with the dressers in Ulanga in the mid-1940s.[39] Dressers in Government service, like the one posted at Chonde labour camp, had sometimes earlier been recruited for government medical services. In this case, the dresser had been engaged in 1919.[40] The dressers in Native Authority services had begun their careers with the rise of the rural dispensary system.

At the beginning of the Native Authority (N.A.) dresser system, the chiefs were probably asked to provide "boys" for training. Therefore, while a series of dressers had mission school training, some of them also had good ties to the chiefs. In 1933, the N.A. dispensary at Luhanyando, opened in 1930 under the authority of *Mwenye Mchamu* Mponda, was attended by a dresser with the name of Mohamadi Mponda.[41] But this dispensary was seen by the British administration as serving too few people and was wound up in about 1934.[42] Ironically, the first Sleeping Sickness cases diagnosed in the Ulanga District came from the area under Mponda. Therefore, a better trained African Hospital orderly, Thomas Chirwa, was sent there to investigate and to provide medical services.[43]

Although there was a dispensary in Chief Undole's place in Merera from at least 1931, a dresser by the same family name, Lukasi Undole, seems not to have worked there.[44] In 1933 Lukasi Undole is reported at Boma ya Lindi much further up the Kilombero valley. Undole worked as a tribal dresser for many years. He was reported in Malingwe and in 1947 in Kotakota/Ketaketa[45], from where he wanted to receive further training in Chirombola, between Ruaha and Mwaya. Lukasi Undole's aim with this transfer was to learn how to use the syringe, but he was refused to move.[46] Unfortunately, we soon lose Lukasi Undole's paper trail. In the 1950s, local historian and descendant of the chiefly family Blasius Undole had learnt to "make use of the power of the written word" (Monson) when working as a clerk in a Native Authority dispensary.[47] Even if, on the basis of the sources used here, we do not know about Lukasi's

[39] TNA 461 16/8: *"Tribal Dispensaries"*, folios 184, 221, 225-189. The book was entitled: " Uchunguzi wa asili za magonjwa kwa darubini".
[40] TNA 61/129G: A. T. Culwick, *Letter A.D.O. Kiberege to P.C.E.P. Kiberege 03.11.1933*.
[41] I found another man by the name of Mponda in the documentation, James Mponda, a Hospital Assistant, who was sent to Malinyi in 1942 to fight the Cerebral Menengitis Epidemic there. TNA 461/8/4: Tanganyika Territory District Office Kiberege, *Letter to DO Mahenge. 20.10.1942*.
[42] TNA 61/129G folio 38ff: *Report [by SAS Mahenge] on Inspection of Medical Out-Stations. Mahenge and Kiberege Districts [07.01.1934]*.
[43] TNA 61/129H: *A report on Sleeping Sickness in the Ulanga District. [probably by G. Maclean]*. Chirwa was made into a "Sleeping Sickness orderly" and soon reliefed by African District Sanitary Inspector Seleman Kipande: TNA 61/3/xiii/H: A. T. Culwick, *Monthly report for the month of Feburary 1940. Kiberege Division. Ulanga District*. Chief Mponda's people were resettled and a Sleeping Sickness was provided.TNA 461/27/1: Tanganyika Territory District Officer Ulanga, *Annual Report. Mahenge Division of Ulanga District. 1940*; TNA 461/27/1: Tanganyika Territory District Officer Ulanga et al., *Annual Report. Mahenge Division of Ulanga District. 1941*.
[44] Jamie Monson, *Claims to History*, in The International Journal of African Historical Studies, 2000, p. 549.
[45] In some sources Kotakota or Madabadaba (a village in what today is called Ketaketa ward). The mission station of Ketaketa however was located about seven hours south of Sali and was resettled, probably closer to Ruaha, in the 1940s anti-sleeping-sickness campaign.*Die Schweizer Kapuziner in Afrika. Jahresbericht 1938/39*, 1939; N.N., *Schlafkrankheit im Tanganyika Territory*, in Missionsärztliche Caritas, 1941.
[46] TNA 461 16/8: *"Tribal Dispensaries"*, folio 268.
[47] Jamie Monson, *Claims to History*, in The International Journal of African Historical Studies, 2000, p. 549.

relationship with Blasius Undole, we can still grasp the link between chiefly power, literacy and the dispensary as an institution from this example.

An example of a dresser's ties to the tribal authority is that of Halfani Barakazi, who was reported to be the tribal dresser at the Barakazi (Lukula/Lukara) dispensary in 1933.[48] The area under the Mpogoro chief with about 2,000 subjects was a rather poor area.[49] At least one highly respected healer resided in chief Barakazi's area in the early 1930s, too.[50] In the early 1940s the people residing under Barakazi's chieftaincy were resettled because of the Anti-Sleeping Sickness measures, and the young chief there was up against his – in the words of the British administration – "reactionary father".[51] I cannot say whether Halfani already was the young chief mentioned at the time, but it is not unlikely. Certainly in 1960 he was the nominated chief in the area. At that point in time Halfani got drawn into a conflict with the family of another dresser, Ibrahim Lundenga. The conflict was over land property rights.[52] According to accounts by his family, Dresser Lundenga had been granted a piece of land as compensation in the resettlement process of 1940. But subsequently it seems that, due to Lundenga's absences during postings to other stations, others began to challenge these property rights This episode gives us insight into a problematic aspect of the life of tribal dressers, their mobility, or rather their transferability. Here is the story of Lundenga as told by his family:

> "At that [year, 1940 or 1941] my father was at Chihi working as a Native Authority Drasser [sic!] [...] Though all this [resettlements, the duties of being a head of family] was done, my father did not neglect the art of medicine. He went on working in the N.A. as a Drasser somewhere in the same country at a place called Ilonga, which is about four miles from Mbalaganga (our home). [... ] 1956 [...] my father was transferred from Ilonga to Kichangani N.A. Hospital, leaving his family behind at Mbalaganga which I believe to be our home and where our properties are. [...] 1958 my father was old enough and so he left the service. [...] He suddenly became sick and later he was sent to R.C. Mission Hospital Ifakara. That was in the year 1959. After staying in the hospital for about 13 months he died. That was in 27.06.1960."[53]

This life story shows that Lundenga, who was already considered an "old" tribal dresser in 1944, must have served at least 20 years as a dresser. He had only served at three dispensaries in that period, which means he had fewer transfers than most of his colleagues.[54] Yet his family still ended up in a struggle over claims to over inherited rights to land. The story of another dresser, Fabian Peleka, exemplifies the problematic impact of transfers on family life as well. Peleka was probably from a second generation of dressers trained at the time of the Second World War. He had good credentials at the end of his training (he could "run a hospital, including

[48] TNA 61/129G: Claude Hollingworth Philips, *Tribal Dispensaries at Lukula (Bora Kazi) and Mponda (Luhanyando) (n.d.)*.
[49] TNA 61/334/G/32: *Letter DO Mahenge to PC EP. Mahenge 22.12.1932*.
[50] TNA District Book, District Office Mahenge, No.1 / Language Notes: Eric Reid, *Some Notes on Witchcraft among the Wapogoro*.
[51] TNA 61/104/H/1: A. T. Culwick, *Letter DO Mahenge to PC E.P. Mahenge 24.11.1941*.
[52] TNA 461 A272 vol II: Ramadhani Ibrahimu Lundenga, *Letter to Chairman Ulanga District Council. Morogoro 12.12.1960*.
[53] TNA 461 A272 vol II: Ramadhani Ibrahimu Lundenga, *Letter to Chairman Ulanga District Council. Morogoro 12.12.1960*.
[54] TNA 461/16/5: Morton Kumwenda et al., *Morton reports on Sleeping Sickness dressers as follows [Feb and June 1944]*.

making stock mixture").[55] While in training in Ruaha with the Nyasaland-trained Hospital Assistant Morton Kumwenda, Peleka wrote to the District Commissioner, seeking his support in ordering his wife Kamila to follow him to his workplace in Ruaha. The District office promptly sent a letter to the headman in the village of Kamila. The headman answered soon: The issue had been solved quickly as Kamila had been found at the local mission station and now travelled to the mission station of Itete to be collected there by her husband.[56] The story looks simple, but the difficulties of communication and of travelling, or even transferring a household at that time were considerable. This was not migrant labour where single men moved, but dressers belonged to the group of clerks who had long professional careers which included the possibility and risks of transfers with their families. Peleka probably had to move again in 1947. When the sleeping sickness programme of the dispensaries was about to be concluded, he was on a list of dressers said to be prepared to work in another district.[57] When the closure of a series of sleeping sickness dispensaries was imminent, dressers came under much pressure. Collectively, they petitioned the district administration to keep promises made to the dressers at the time of their training for the anti- sleeping sickness campaign in Ulanga, including a promise of better wages. But now the programme was being abandoned and both jobs and the prospect of better pay seemed to evaporate.[58]

Health was yet another problem for dressers. Johannes Mfanyakazi bitterly complained about his situation in Iragua:

> "I came to the hospital in Iragua in 1940. I stayed there a lot, did become sick and in big danger until transported to Mahenge. I did recover and return to Iragua. After I had returned, always I got pains of many kinds. Swollen legs, furuncles, and until now I don't have a good health. My wife also got a dangerous sickness. She is not bad now, but her health is not good."[59]

He asked, consequently, to be granted a transfer to a healthier post. On the other hand, we see that Mfanyakazi had access to treatment in Mahenge hospital, where government staff was provided for at no cost to themselves. Another of his colleagues, Anselm Amri, even was sent to Dar es Salaam for the treatment of his eyes in 1943.[60]

Fabian Peleka, the man who had asked for his wife to be sent to join him and who was one of a dozen of signatories of the petition for the continuation of their career paths in the sleeping sickness dispensaries, seems to have left government service for a job with the Catholic mission in Sofi at the end of the 1940s. A dresser by the name of Fabian got involved in a conflict with Dr. Adelheid Schuster, a German mission doctor present in the Capuchin Mission at that time. Her views on the tribal dressing system in Ulanga were very negative: "in every small

[55] TNA 461/16/5: Morton Kumwenda et al., *Morton reports on Sleeping Sickness dressers as follows [Feb and June 1944]*.
[56] Letters Peleka, Kumwenda, D.C. Ulanga, Nduna Hassani Mgendera in May 1943. TNA 461 16/8: *"Tribal Dispensaries"*, folios 116-118.
[57] TNA 461 /16/5: G.V. Harischandhayan et al., *Letter Medical Mahenge to Dirmed. Mahenge, 16.12.1947*.
[58] TNA 461 /16/5: Omari Mbunga et al., *Petition to DC Mahenge. 01.11.1946*.
[59] TNA 461 16/8: *"Tribal Dispensaries"*, folio 84. My translation.
[60] TNA 461 16/8: *"Tribal Dispensaries"*, folio 109.

village we have a dresser with outrageous skills, a legacy of [the district officer] Mr. Culwick".[61] She was not alone with this view. In the same year, Morton Kumwenda in Ruaha informed the District Commissioner that he was not very happy with the medical knowledge of dressers that had been sent to him to learn to give injections. Kumwenda held that these men "knew nothing of dispensing works even a little." Kumwenda felt that they needed two or three months of training, "because it is of no use to teach them how to give injections without dispensing and how to use the scale properly". It was also necessary to equip the dispensaries where these dressers worked with scales, mortars, bottles, syringes etc.[62] But in the case of Fabian Peleka the absence of professional knowledge was certainly not the point in case, as Kumwenda had given him great credit after he had trained Peleka for eight months in 1943.[63]

Schuster's charges against the dresser Fabian were quite similar to the ones she had raised against Tobias in Kipatimu in the coastal region, where she had been posted previously. The sources read as if Tobias did not accept Schuster's authority easily and that she was unhappy with his work and felt he concentrated too much on learning English. Dresser Tobias subsequently decided to go to Kilwa for a test of his knowledge by the Indian doctor in Kilwa.[64] It is not surprising that Tobias wanted to advance socially and economically. English literacy certainly was already a key element in the hierarchy of African medical professions at that time, and dressers in Ulanga were being trained by an English-speaking African, notably the African Dispenser Morton Kumwenda from Nyasaland. The conflict Schuster had in Sofi with Fabian Peleka was also about medical authority. Peleka was accused by Schuster of working for his own profit and also of misusing of penicillin for the treatment of gonorrhea. Schuster was against his transfer to Mpanga, where dresser Fabian would have worked under less supervision.[65]

A career path through various kinds of institutions was quite likely. Another dresser with strong links to the Mission, as his Christian first name indicates, was Florian Muharabu. From the archival documentation it seems he was educated at an Ifakara mission school before he was trained as a tribal dresser in 1927, probably at Mahenge hospital where he spent 9 months. He attended a three-month refresher course in Kiberege in 1929, and spent 7 years in government service in Mgeta from the late 1920s to the early 1930s and again in the late 1930s. In the 1930s he also worked for about five years at Ifakara "Hospital", i.e. with the missionary sister Arnolda, but he was paid from the Native Treasury. Like Fabian Peleka, he is one of more than a dozen of

[61] PAL 1061.4: Adelheid Schuster, *Letter to E. Maranta. Kwiro 24.08.1947*. On Schuster see chapter 6.
[62] TNA 461 16/8 Vol I: Morton Kumwenda, *Letter to DC Mahenge. Ruaha Hospital 05.04.1947*.
[63] TNA 461 16/8 Vol I folio 143: Morton Kumwenda, *Letter to D.O. Mahenge, 29.11.1943*.
[64] PAL 1061.4: Adelheid Schuster, *Letter to E. Maranta. Kipatimu, 22.05.1940*; PAL 1061.4: Adelheid Schuster, *Letter to E. Maranta. Kipatimu 15.08.1941*.
[65] PAL 1061.4: Adelheid Schuster, *Letter to E. Maranta. Kwiro 03.11.1950*. He might have considered this a standard procedure. The conflict here might be about the use of antibiotics for treating STDs. STD treatment had not always been popular with the mission, especially not in Kipatimu. See the commentary on: *[photograph] Das Spital von Kilwa*. PSKO.

dressers who petitioned the District Commissioner in 1946 when the Sleeping Sickness dispensary scheme was meant to be halted.[66]

Another man with a long career and who passed through even more varied medical establishments was dresser Martin Mohamed.[67] Dresser Martin had served in leprosy and in regular as well as in sleeping sickness dispensaries, probably under both Government and Native Authority employment. He had probably trained with Muharabu in Mahenge in 1927. Martin Mohamed was a Mbunga who had been to both mission and government schools up to Standard III. After training for nine months he worked for more than ten years in Mkasu and in Kilosa kwa Mpepo. He was taken to Mahenge again in 1929 to be trained in Leprosy care for a week, since Kilosa kwa Mpepo was the closest to the Government Leprosy camp at Mkasu.[68] In Kilosa he earned a salary of 15 Shillings per month, which seems to have been the regular pay for a trained dresser with long experience posted in a Native Authority dispensary in the 1930s and early 1940s. In October 1939, he was stationed at Mbingu, where he treated between two to ten patients per day. At that time he was reported to be a very keen worker though afflicted with leprosy himself, even though his condition was improving.[69]

Some of the older dressers were hired again in the early 1940s, when there was a great expansion of the dispensary system. One of them was Rafael Myonga, who had worked in Ruaha in the early 1930s. In 1943 he had quit his profession or might even have been fired, but was now taken into training again. Kumwenda was not happy with the capabilities of this man, whom he considered to be headstrong and over-confident in applying what little knowledge he had learned. Policing the boundaries of biomedicine was not always without conflict for Kumwenda, but in the case of Myonga, who stayed in service until at least 1946 when we lose his paper trail, Kumwenda was successful. Myonga's career becomes almost symbolic of a qualitative jump in dresser medicine at the end of the 1940s. At that time, some chiefs had become quality conscious, and the second training of Myonga, which took eight months under the auspices of Morton Kumwenda produced a surprisingly fine result. Myonga was considered

[66] TNA 61/129H: George Maclean, *Notes on Ulanga District [recieved 18.01.1940]*; TNA District Book, District Office Mahenge, No.1 / Medical: N.N., *List of Tribal dressers in the Kiberege Division of the Ulanga district*; TNA 461 /16/5: Omari Mbunga et al., *Petition to DC Mahenge. 01.11.1946*.

[67] There were three or four different men called Martin working in medicine in the 1930s and 1940s in Ulanga. It is therefore difficult to identify 'Dresser Martin' clearly. If I have confused the information about different individuals called Martin, despite my best efforts, I believe it still provides a valuable insight. Another Martin was Martin Msowaya, who worked at Kiberege Government Dispensary in 1933. Martin Kayamba is still rememberd in Ruaha: In 1944 he was posted to Ruaha probably after another spell of training at the Chilombero/Ruaha Sleeping Sickness dispensary under the control of Morton Kumwenda..

[68] TNA 450/34/3 Medical Officer Mahenge, *Extract from the letter no 1/1/3(30 of 07.01.1930 to Dir of Med Services*. Mkasu at that time served as an administrative post before the latter was moved to Kiberege and the Leper camp was probably given up in 1930.

[69] For the years from 1943 it is difficult to distinguish Martin Mohamed from Martin Nkwanga. It is not impossible that these were the same men Nwkanga was reported to have been posted in Mofu (neighbouring Mbingu) and Ilonga (South of Ruaha) at the very times that M. Mohamed was stationed in the Mbingu and Ruaha.

> "good in dressing work, in all difference (sic) parasites of the blood, feces sputum nasal smear etc. [He] can give all difference injections i.e. intramuscularly intravenous and subcutaneously, [he is] also very good in dispensing work according to [his] rank."[70]

In fact, Kumwenda now considered him to be excelling the category of the ordinary dresser, and Kumwenda suggested that Myonga should be given an increment in wages as well as a uniform. The re-training of Myonga by Kumwenda is an example of the rapid progress of medical professionalization, including professional symbols, in the early 1940s and the extent to which this process was in the hands of Africans.

It is very difficult to detect the women in the dressers' profession. In Ifakara, where Sr. Arnolda started a maternity clinic in 1937, an African midwifery assistant was already on the staff in 1935.[71] The two women 'dressers' in the government sector that I came across were Veronika Hubert and Deisderia [sic] Kassiam. Both of them were trained in 1943, after they had applied to be trained as dressers and midwives. Both women were comparably well educated, and had passed Standard VII. "It seems to me that they might turn out valuable for work amongst the women and children," A.T. Culwick wrote to Morton Kumwenda in 1943, and he wanted "them to receive training in the nature of disease, its prevention and cure."[72] Kumwenda gave them excellent testimonials in 1944. At that time Veronika Hubert was sent to work at Mahenge hospital, and Deisderia [sic!] Kassiam was about to return to Ruaha dispensary, after she had had her baby.[73] Most women hired for dispensary work were so-called 'Ayahs'. Ayahs were part of the medical establishment, female assistant nurses or nursemaids.[74] The colonial administration was actively looking to get the missions as well as the chiefs to provide girls suitable to be trained as ayahs.[75] In Egypt and the Sudan *dayas* were a well established category and in India they were called dai – reminding us of the links in medical matters across the imperial Indian Ocean.[76] In 1948 the District Officer claimed to have one dresser and one ayah working in each of the district's dispensaries.[77] In 1947 five women were listed as ayahs, serving at five different dispensaries.[78] For three of them, we know where they came from and that they

[70] TNA 461 16/8 Vol I folio 143: Morton Kumwenda, *Letter to D.O. Mahenge, 29.11.1943*.
[71] See chapter 5.
[72] TNA 461 16/8 Vol I: A. T. Culwick, *note to Hosp. Assist. Morton Kumwenda. 27.04.1943*.
[73] TNA 461/16/5: Morton Kumwenda et al., *Morton reports on Sleeping Sickness dressers as follows [Feb and June 1944]*.
[74] Amina Ameir Issa, *Stinkibar to Zanzibar*, 2009; Heather Bell, *Midwifery Training*, in The Journal of African History, 1998. Ayah has become a term used for general housemaids as well, an maybe even in the 1940s already had this connotation in an urban, multiracial context: D. G. Maillu, *The ayah*, 1986. James R. Brennan, *Realizing Civilization*, in Social Identities, 2006, p. 415.
[75] TNA 461 /16/5: G.W.S. Conan-Davies, *Letter DC Mahenge to M. Kumwenda, 01.06.1946*.
[76] L. El-Hamamsy, *The Daya of Egypt: Survival in a Modernizing Society*, 1973; Hibba Abugideiri, *Gender*, 2010. The term in India was Dai: Supriya Guha, *From Dais to Doctors*, 1998. Ayah however was a term for a nursemaid in India: David Arnold, *Colonizing the Body*, 1993, glossary p. 323. Compare the word for doctor used both in Kiswahili as for the modernized Indian healer: Projit Bihari Mukharji, *Nationalizing the Body*, 2009. John B. Kabeya, *Daktari Adriano Atiman*, 1978.
[77] TNA 461/27/1: Tanganyika Territory District Commissioner Mahenge et al., *Annual Report Ulanga District 1948*.
[78] Magdalene bt Hubert at Kichangani dispensary, Antonia bt Mgeketa at Iragua, Kristina bt Kosmas at Itete, Maria bt Paul at Mtimbira and Marcellina bt Njembe at Sofi. TNA 461 /16/5: M. Kumwenda, *Letter to DC Mahenge. Ruaha Hospital 16.01.1947*. Mgeta and Mbingu were still planned to receive one ayah. TNA 461 /16/5: M. Kumwenda, *Letter to DC Mahenge. Ruaha Hospital 18.07.1946*.

had passed standard II, IV or V respectively, all at the central girl's mission school in Kwiro.[79] Ferena Kipekipeki had been serving in Kiberege from about 1939 to at least 1945, and earned not much less than her male dresser colleagues.[80]

Other categories of assistant worked in the dispensaries too. The designation 'sweeper' seems to imply a non-medical role. But it would be unimaginative to assume that sweepers were not in contact with patients. I have found at least two examples of 'sweepers' trained as dressers in the mid 1940s. Boniface Makende had worked as a sweeper at Mgeta and Lazaro Mbanile had been a sweeper in Kiberege but would eventually himself be in a position to ask for a sweeper to assist him when he was posted as a dresser in Malinyi in 1948.[81] Looking at the cohort of dressers in detail, one finds that not all of them were actually literate. Second hospital orderly Mgobiwa in Kiberege Government Dispensary in 1943 was reported to be illiterate, but his pay was only a fraction less than that of his colleague Paulo, who had nine years' experience, and was considered an "industrious lad" who helped with doing microscope work.[82] Paulo was deemed worthy of "upgrading" though, which could mean better pay, or advanced training. A career through different levels of dispensary professions was not impossible. By the mid-1940s dressers had definitely become more than the local African man posted in a dispensary, they were health workers with a chance for a 'modern' career through bureaucratically organized state institutions.

## Mission Dispensaries

### Sofi

We have seen that some dressers changed into mission dispensaries. But were mission dispensaries the same as government dispensaries? They were not, as they had European staff, often provided some in-patient facilities and injections, and always added a strong Catholic element to the medical treatments offered. Mission dispensaries included explicit Christian elements: they were open to patients from all religious creeds but they also tried their best to make all of them receive Catholic religious education.[83] Religious education was most likely to contain explicit allusions to the power of Christianity against evil spirits.[84] The Catholic even

[79] TNA 461 /16/5: M. Kumwenda, *Letter to DC Mahenge. Ruaha Hospital 07.07.1946*.
[80] TNA 450/1230/2: Saidi Rupia, *Kiberege Dispensary. Concise Annual Report for 1944 [03.01.1944]*; TNA 450/439: Sub Assistant Surgeon Kilosa, *Report on Kiberege Dispensary. Visited on 15.09.1943. Kilosa 21.09.1943*. With regards to salary the same applies to the Ayha bt Fundi at Mahenge Hospital.
[81] TNA 450/1230/2: Saidi Rupia, *Kiberege Dispensary. Concise Annual Report for 1944 [03.01.1944]*. and TNA 461 16/8: *"Tribal Dispensaries"*, folio 285.
[82] TNA 450/439: Sub Assistant Surgeon Kilosa, *Report on Kiberege Dispensary. Visited on 15.09.1943. Kilosa 21.09.1943*. Paulo is difficult to identify. He might had a relative working in Mahenge hospital. He was still in Kiberege in 1944. TNA 450/1230/2: Saidi Rupia, *Kiberege Dispensary. Concise Annual Report for 1944 [03.01.1944]*.
[83] PADSM 153/3: *Quartalbericht von Ifakara. Weihnachten 1937*.
[84] Ansgar Häne, *Die seelische Einstellung des Negers zu Krankheit und Tod*, in Missionsärztliche Caritas, 1939, pp. 4-5 with an example from such teaching, although not explicitly in the context of the hospital.

infused the form of drugs: for example, Thymol powder, the treatment of choice against hookworm at the time, was baked into a wafer of the type used for communion.[85]

But the Catholic mission did not have many specialized medical mission institutions in Ulanga in the 1930s and 1940s. Sofi was one of the earliest and was for a long time one of the most important stations of the Capuchin mission.[86] Sisters came to Sofi by 1923 and soon ran a dispensary in a small room.[87] The Sofi mission covered an area "as big as a couple of Swiss cantons taken together" with about 20,000 African inhabitants of whom 1,800 were recorded as being baptized in 1926.[88] The size given here clearly indicates that Sofi was meant to service an area comprising of a series of Native Authorities. The Sofi Mission was staffed in 1943 by two European priests, two Brothers and five Sisters plus an unknown number of African staff.[89] At that time Sofi had, according to Medical Officer stationed in Mahenge, a

> "well-equipped Dispensary under the care of a trained Nursing Sister. Injections for Yaws and Syphilis are given weekly and minor ailments treated. Attached to the Mission is an in-patient Department [with] wards for males and females."[90]

Looking back on their practice in the 1930s the sisters reported that the Sofi dispensary saw about 100-300 sick people every week, some of them being carried there by their kin. Sometimes the resident Fathers would assist the Sisters in matters medical using the opportunity to give lectures to the patients, which was, according to the Sisters, were received with great joy.[91] In 1938 Sofi engaged in almost 50,000 consultations, of which 18,000 included administrations of injections. Almost 9,000 received dressings for wounds and ulcers, 6,500 were treated for problems with the eyes or the ears, 8,000 for intestinal problems, 4,500 for dermatological problems, and more than 800 received treatment against hookworm. Some 250 patients were taken into the wards, of whom 34 died.[92] Additionally, local leprosy cases had always been treated in Sofi.[93] In the late 1940s the Mission established a "new hospital" with seven wards and almost 30 beds, two large dispensary rooms and a shaded terrace.[94] At least one fully trained mission sister nursed the patients, assisted by three African dressers.[95]

## Ifakara

Mission dispensaries took a seriously local tinge in terms of their medical culture. In 1942 a Senior Medical Officer reported of the mission dispensary in Ifakara that it was "kept in

[85] In a report from Msimbazi, close to Dar es Salaam: Sr. Innozentia M. Hürlimann, *Aus den Missionen. [Bericht über Msimbazi, Krankenstatistik]*, in Providentia, 1938.
[8686] Institutsarchiv Baldegg BIII, 6, 1: *Chronik Sofi*. Also the first African Bishop of the Diocese of Mahenge seems to have been from Sofi.PADSM 208/2: P. Berthold von Arx, *Unser schwarzer Neupriester Elias Mchonde feiert sein erste hl. Messopfer in Sofi am 05.09.1948*.
[87] Institutsarchiv Baldegg BIII, 6, 1: *Chronik Sofi*.
[88] *Die Schweizer Kapuziner in Afrika. Jahresbericht 1923*, 1924; PADSM 208/Sofi 1: Ansgar Häne, *Chronica Sofiana 1927*.
[89] Veit Gadient, *Die Missionen der Schweizer Kapuziner*, in Katholisches Missionsjahrbuch der Schweiz, 1934.
[90] TNA 61/129G: Claude Hollingworth Philips, *Letter MO Mahenge to DMSS. Mahenge 18.09.1933*.
[91] Sr. M. Lina, *Aus den Missionen*, in Providentia, 1941.
[92] Ansgar Häne, *Krankenfürsorge im Apostolischen Vikariat Daressalaam*, in Missionsärztliche Caritas, 1938.
[93] TNA Acc.450/HE/178/16: Gerard Fässler, *Letter to Direct. of MS, Kwiro 17.09.1935*.
[94] Isaias Duss, *Sofi*, in Jahresbericht der Schweizer Kapuziner in Afrika 1950, 1950.
[95] TNA Acc.450/HE/178/16: Edgar Maranta, *Details of Medical Personnel, 28.12.1949*.

European style, but the equipment has a continental complexion."[96] There were beds, but many were vacant, because "patients, especially maternity ones, adopt a half 'in' and half 'out-' patient role." Sr. Arnolda, the nurse in charge of the Ifakara mission dispensary also practiced "successfully with the diverse herbs and roots used by Africans in the treatment of various 'Negro-Diseases'". An example is "Kapatula", a disease Sr. Arnolda identified in discussions with her patients as a disease who was said to rage in Mwanza and which the Africans had first encountered when the British came there in their short trousers, known as Kapatula.[97]

To a substantial degree, the interest in African herbal medicine was also a result of a specific tradition in Catholic medicine. Dispensaries had a very long tradition in convents, where a distinct and well-regarded type of medicine, "monastery medicine", had thrived since the Middle Ages, and they were also a long established field of knowledge production by Catholic missionaries.[98] Sr. Arnolda engaged in producing the alcohol needed for disinfection, but also as a medicine (and a drink).[99] The missionary dispensary in Ifakara also consisted of a well-arranged collection of pharmacopeia.

**Sr. Arnolda working in her dispensary in Ifakara, no date[100]**

For decades travelers to Africa had been interested in African pharmacopeia.[101] In the 1930s in East Africa, doctors, ethnographers and missionaries discussed African knowledge and

[96] TNA 450/439: W.A. Young, *Report of S.M.O. to Ulanga District 10.08.1942-22.08.1942 [28.08.1942]*.
[97] PADSM 153/3: *Quartalbericht von Ifakara. Ostern 1937*. As a phrase "Kaputula" represents the memory of the influenza epidemic of 1918: Gregory Maddox, *Disease and Environment*, 2010, p. 208.
[98] A research group on "Klostermedizin" exists in Würzburg and the exhibit at Deutsches Apotherkermusem in Heidelberg displays an original dispensary. Sabine Anagnostou, *Jesuits in Spanish America*, in Pharmacy in History, 2005.
[99] Rolf Diethelm, *Erinnerungen an Ifakara. Aus den eigenen Notizen (Tagebuch) über meine Tätigkeit in Afrika 1959/1960*, (Altdorf2006), p. 9.
[100] PSKO: Foto "Apotheke" from large untitled Album with linen binding, no page numbering.

use of medical agents, and some missionaries actively worked against the rejection of 'bush medicine' by the Catholic catechism.[102] In Ifakara, Arnolda asked for herbal medicine from Switzerland, herbal teas in particular, to be sent to her for use in the dispensary.[103] A critical position of many missionaries towards "soulless" scientific medicine was, according to Bruchhausen, an important impetus that underscored the missionaries' use of herbal medicines. This was certainly underscored by the long tradition of herbal medicine gardens in convents, but one should not forget that many if not most drugs still today are based on natural ingredients. As synthesized or industrial pharmacological products were rare in Ulanga, because they were expensive and difficult to buy, transport, and store, Sr. Arnolda tried to use herbal teas and local herbs as much as possible.[104] In a letter the Sister reported that "in the rainy season we roamed the bush for weeks in the company of two herbal doctors and then planted the medicinal plants in our herbal garden. Slowly we succeeded in discovering the secrets of their healing power. We were also trying to help the poor by using the means available to them. We got Totaquin directly from the bark of a tree, and used it as a tea to treat Malaria."[105]

P. Kunibert Lussy reported that this enterprise had produced about 200 recipes by 1948, but he was all the more convinced that the prices for herbal medicine administered by African doctors were high while the medical effect was often missing.[106] Clearly, Arnolda believed in the healing power of herbal medicine and that African knowledge had some control over its functions, and A.T. Culwick, the colonial administrator did so, too.[107] Arnolda would later assist a series of researchers in collecting information on local health care practices. She paved the way for Haerdy to do his work with local herbal doctors.[108] For Rudolf Geigy, she opened the doors for him to take pictures, to film and to document local circumcision and initiation ceremonies.[109]

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[101] Patrick Harries et al., *Medizin und Magie*, 2012, p. 90.

[102] W.D. Raymond, *Native Materia Medica*, in Tanganyika Notes and Records, 1936;1938; Hans Koritschoner, *Details of a Native Medical Treatment*, in Tanganyika Notes and Records, 1936. Walter Bruchhausen presented the history of interest in pharmacopeia in German East Africa and in German-language missions in the 20th century, and how herbal medicine was constituted as a field apart from 'Magic' in Africa Walter Bruchhausen, *Medizin zwischen den Welten*, 2006, pp. 152-160. On the teas, which came from Switzerland to the mission stations via Sr. Innozentia see: Sr. Innozentia M. Hürlimann, *Unsere Teeverwalterin dankt*, in Missionsbote der Schweizer Kapuziner in Afrika, 1937. Large amounts and a wide range of teas were collected and also popular with the African clients. Ansgar Häne, *Die seelische Einstellung des Negers zu Krankheit und Tod*, in Missionsärztliche Caritas, 1939. Other missionaries also considered African herbal medicine to be efficient (but expensive), see P. Medard Baumgartner, *Medizinkult der Wabena*, in Missionsbote der Schweizer Kapuziner in Afrika, 1936.

[103] Sr. Bernadette Gabler, *Die Sorge um unsere kranken schwarzen Bürder und Schwestern im Apostol.Vikariat Daressalaam (Ostafrika)*, in Missionsärztliche Caritas, 1935. For a similar practice by a Swiss nurse in South Africa see Sr Rudolfina Metzler, *Missionstheresli*, 1937, pp. 32, 42.

[104] Fritz Haerdi, *Eingeborenen-Heilpflanzen*, 1964, p. 9; Sr. Bernadette Gabler, *Die Sorge um unsere kranken schwarzen Bürder und Schwestern im Apostol.Vikariat Daressalaam (Ostafrika)*, in Missionsärztliche Caritas, 1935.

[105] Sr. Marie-Ruth Ziegler, *Weisse Mama von 5000 Kindern*, in Ite, 1997.

[106] Kunibert Lussy, *Die Medizin im Dienste der Mission*, in Missionsärztliche Caritas, 1948, p. 6.

[107] They also give a substantial list of herbal medicines used by traditional healers: A. T. Culwick et al., *Ubena of the Rivers*, 1935, pp. 388ff. Walter Bruchhausen desribes a strong tendency of Ifakara missionaries to see placebo effects in place, but it is improbable that Sr. Arnolda would have thought in that manner. Walter Bruchhausen, *Medizin zwischen den Welten*, 2006, pp. 62-64.

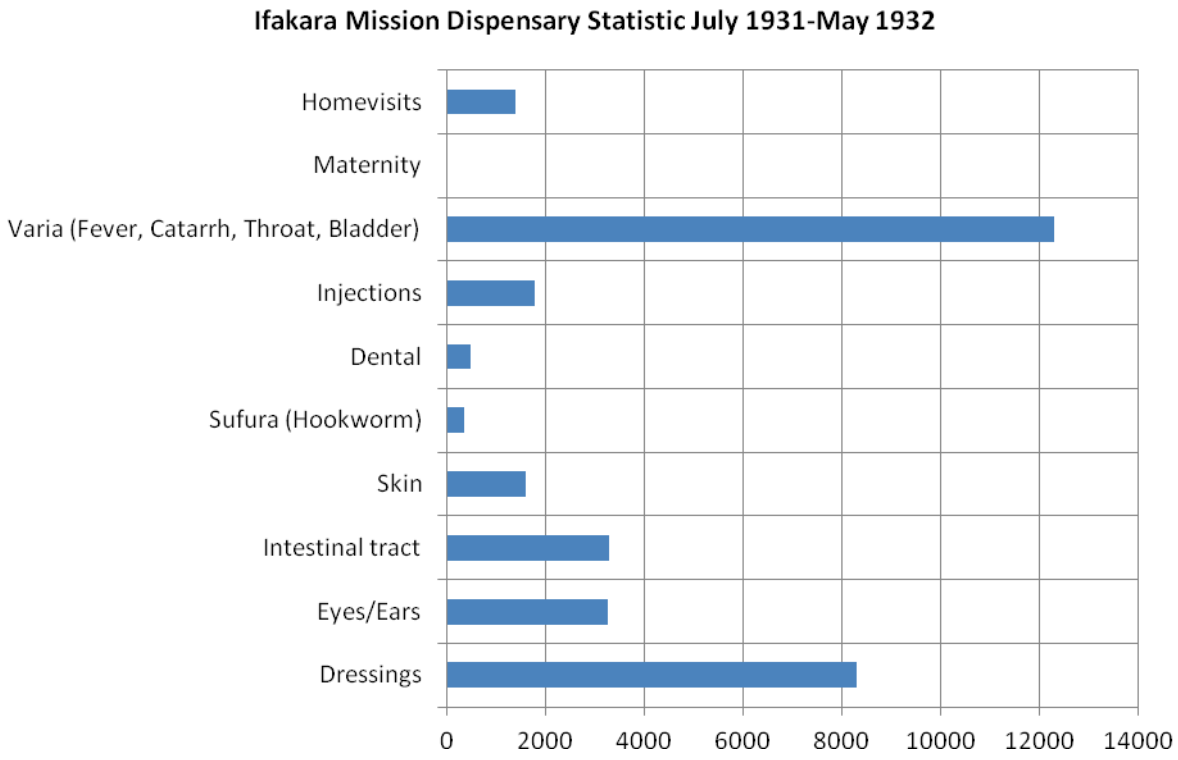
[108] Fritz Haerdi, *Eingeborenen-Heilpflanzen*, 1964.

[109] Rudolf Geigy et al., *Mädchen-Initiationen*, in Acta Tropica, 1951. Rudolf Geigy, *Forschungsaufenthalt bei der Kapuziner-Mission in Tanganjika*, in Jahresbericht der Schweizer Kapuziner in Afrika 1950, 1950.

If the example of herbal medicine tells us something about Sr. Arnolda's links to African knowledge, it also highlights the process of constituting biomedicine as a practice, a theme that Nancy Rose Hunt addressed in her "colonial lexicon".[110] Feierman and Janzen have already argued that in Africa the phenomenon called biomedicine was "adopted, administered, controlled, licensed, changed, and situated alongside, even with, pre-existing traditions."[111] We must infer that the way mission medicine was shaped in this conversation was, to some degree, different from that in the dispensary under the African dresser. But this is difficult to judge and, certainly, Sr. Arnolda explicitly reached out to access African knowledge. Thus, when Sr. Arnolda looked for a herb growing on the slopes of an Ulangan hill (she heard of the herb through her communication with Ulangan healers, and had learnt how it was possible to acquire the herb) to boil and dispense in her small hospital, maybe saying a prayer at the same time, the very essence of the medicine practiced here is its transcendent character and the many ways in which it could be experienced and described.[112]

As a dispensary, Ifakara recorded fewer consultations than Sofi, but it was still a staggering number of 28,000 treatments including 74 midwifery cases.[113] The number of consultations had remained steady in Ifakara since the early 1930s. But here in Ifakara injections were much less commonly given, which almost entirely explains the smaller number of consultations. The emphasis in Ifakara, since the early 1930s, was placed on maternity services.[114]

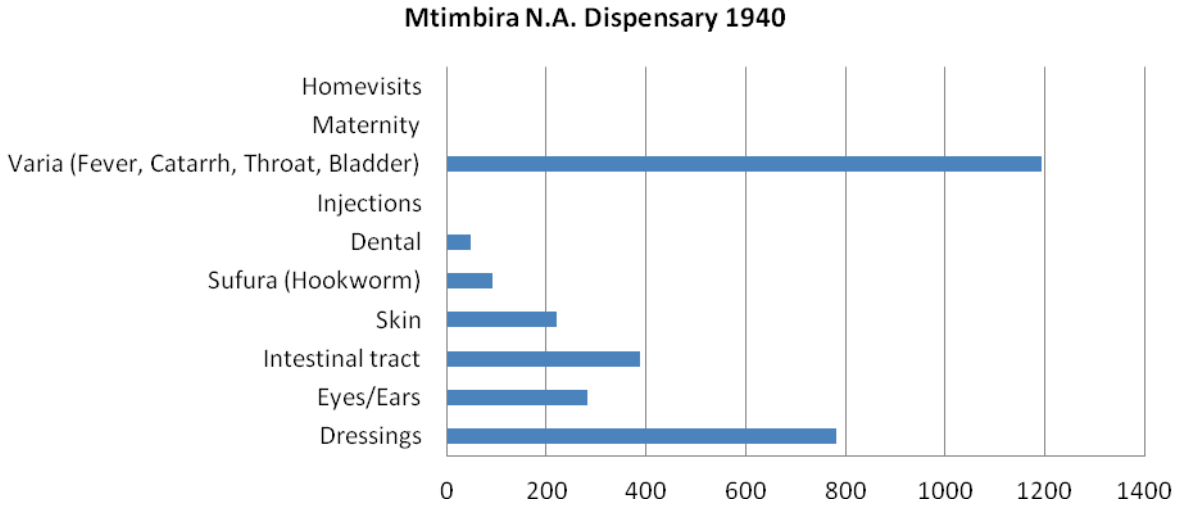
[110] Nancy Rose Hunt, *Colonial Lexicon*, 1999, especially pp.7-8, 159-195.
[111] John M. Janzen et al., *Introduction*, in Social Science & Medicine. Part B: Medical Anthropology, 1979, here p. 240.
[112] Luise White, *Speaking With Vampires*, 2000, especially pp. 89-121 (chapter 123).
[113] PADSM 153/3: Hieronymus Schildknecht, *Jahresbericht 1937/38. Ifakara*.
[114] PAL 1057.J. Ifakara / Briefe: H. Schildknecht: Hieronymus Schildknecht, *Letter to E. Maranta Ifakara 06.04.1932*.

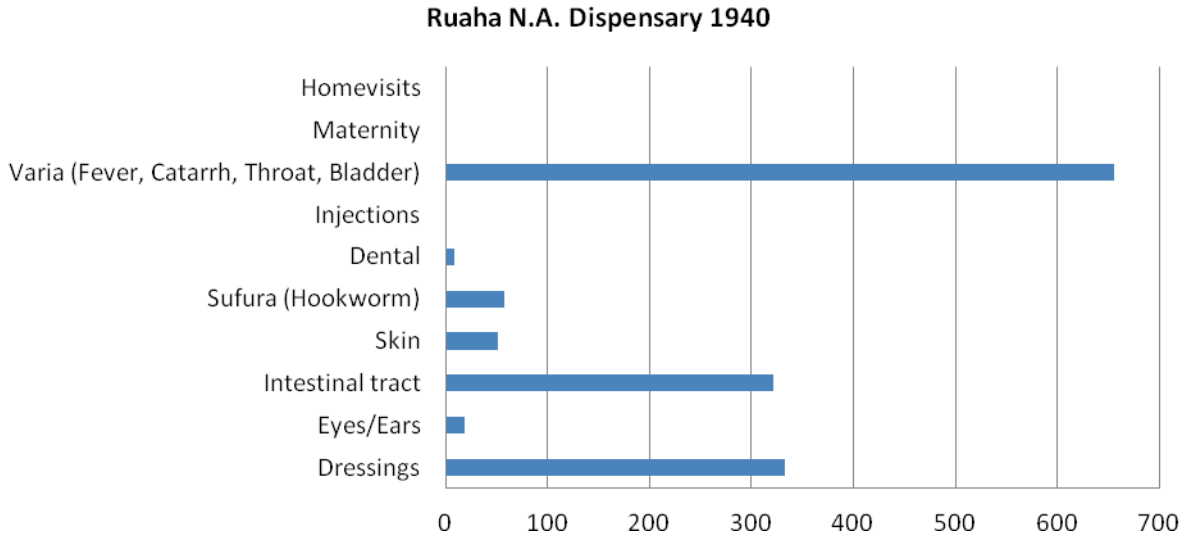



The Chart above shows a total of almost 33,000 consultations by an unknown number of individual patients at the mission dispensary in Ifakara within a period of less than a year.[115] The statistics are not very detailed, with a very broad category of 'various diseases'. There was a marked peak for all treatments in March and a lesser peak in August. The category of Varia, including Fevers, recorded its lowest numbers in November.

If we compare these numbers with those of the Mtimbira dispensary[116] seven years later, we recognize that the services were very similar. But they were quite different from Ruaha, where there was less than half the number of treatments done in Mtimbira, with a huge category of 'varia' and lots of intestinal tract issues, but hardly any specific treatments for skin, eye, and ear problems.

[115] PAL 1057.J.Briefe: Schwestern v. Baldegg; Einheimische Schwestern; Privater: Schwester M. Arnolda, *[Statistical charts treatments given at Mission Dispensary Ifakara]*.The numbers collected by the nurse differ slightly from the average users mentioned in PAL 1057.J. Ifakara / Briefe: H. Schildknecht: Hieronymus Schildknecht, *Letter Ifakara 27.02.1932*. While Schildknecht gives an average o 50-70 per day, Sr. Arnolda counted just under 2,000 users visting the dispensary.
[116] Numbers collected from: TNA 461 16/8 Vol I: *Analysis of Diseases treated in Mahenge Division Tribal Dispensaries 1940*. Note that categories were not fully consistent.




Home visits were only noted for the mission dispensary. The mission sister also laid an emphasis on visits at the homestead of the patient.[117] Sr. Arnolda took the girls from the mission school for training in home-based care.[118] Often these visits were also a struggle about the control of healing and the procedures involved, and ideally the patient would be brought to the mission station.[119] In this manner, the medical practice of the Mission Dispensary installed a new approach towards the patient, subjecting him as much as possible to the new regime of medicine. These were also novel ways of intervening in the private sphere which came as part and parcel of colonial governmentality. In 1937 it was debated in Government whether dressers were to be allowed to enter the house of an individual for medical purposes, against the will of the patient. The answer was yes, if it was "for the purpose of examining buildings [...] under section 9 of Infectious Diseases Ordinances, if the powers of a Medical Officer of Health under

[117] Sr. M. Margrith Bösch, *Schwesternarbeit in der Mission*, in Providentia, 1934; Solana Lustenberger, *Missionsarbeit der Schwestern*, in Katholisches Missionsjahrbuch der Schweiz, 1937.
[118] P. Aquilin Engelberger, *Bauen in Afrika*, in Seraphisches Weltapostolat des Hl. Franz v. Assisi, 1932, pp. 204-206.
[119] P. Kunibert Lussy, *Von Hütte zu Hütte*, in Seraphisches Weltapostolat des Hl. Franz v. Assisi, 1934, pp. 19-20; Sr. M. Adelina Laube, *Aberglaube tötet die Liebe*, in Missionsbote der Schweizer Kapuziner in Afrika, 1938.

this section are conferred upon him by the DO, in the absence of a duly qualified MO". In no case however can a native dresser "perform a professional action on an individual without the consent of that individual."[120]

## The mission dispensary and state medicine

At the same time the Mission Dispensary reached out and linked to state medicine in a direct way. In 1935 the Mission in Ifakara had cooperated with the Government in a campaign against hookworm (Ankylostomiasis).[121] During a visit in Ulanga, R.R. Scott, the Director of the Medical Department in Dar es Salaam had arranged with the Mission that it partnered Government in a campaign against Ankylostomiasis, then and now also known locally under its Kiswahili term, *Safura*. The partnership centered on Ifakara and combined the work of an African dresser, who went out to seek patients, with that of Sr. Arnolda who then treated the patients in the dispensary in Ifakara.[122]

It also entailed public speeches by Scott, resulting in an enthusiastic reaction from the Chief in Ifakara who ordered all his staff to join in the search for patients.[123] Culwick, too, gave the "most theatrical talks on hookworm so that now hundreds of people discus the *'dudu mbaya sana*' [the very bad worm]." Culwick also found that the majority of people believed that Scott personally had discovered the hookworm.[124] At the end of the year 1935, the campaign ran in all the larger population centres in the Kilombero valley, that is in Ifakara, Kiberege and in the Ubena area of Chief Towegale, who – together with four of his wives – personally joined the campaign as a 'voluntary worker'.[125]

The hookworm campaign shows how state medicine, Native authority and mission activities came to sit in the same boat. This sheds some light on the role of disease in articulating the political and cultural ties in the colonial situation.[126] Obviously, with the hookworm, a new object was introduced into the ontology of illness. Whether people felt this was also a new affliction cannot be reconstructed, but they most probably felt that it was a real health issue which was linked in some way to the trinity of modernizing powers and its institutions. Hookworm might indeed have been a rising problem at the time, particularly in an area like Ifakara which saw more concentrated settlement, and a decline in the sanitary situation at the

[120] TNA 13571/II: *Docs 398 - 400, 30.09.1937 und 02.10.1937*.
[121] For a comparative history of hookworm, and how it has shaped global health from the periphery see Steven Paul Palmer, *Launching Global Health*, 2010. Hookworm is not a tropical diseases, however, as can be easily understood from the role it played in the building of the St. Gotthard railway tunnel through the Swiss alps in the 1880s: R. Peduzzi et al., *Ancylostoma Duodenale And The Saint Gothard Anaemia*, in British Medical Journal (Clinical Research Edition), 1983.
[122] *Afrika-Post [Rubrik]*, in Missionsbote der Schweizer Kapuziner in Afrika, 1935.
[123] TNA 450/653 & 450/56: A. T. Culwick, *Extract from a personal letter from the A.D.O. i/c Kiberege to Dr. Scott, 11.09.1935*.
[124] TNA 450/56: A. T. Culwick, *Extract form a person letter from A.T.Culwick dated 22.09.1935 to Dr. Scott*.
[125] TNA 450/56: A. T. Culwick, *Letter to the Dir. of Medical Services. Kiberege 15.11.1935*.
[126] See Phillips for an argument on how epidemics accentuate social configurations: Howard Phillips, *Plague, Pox and Pandemics*, 2012.

time. The combined power of central government, local African authorities and medical staff and the Mission fought the disease mainly with curative means.[127] Culwick was very happy with the results of the campaign, particularly in Ifakara. He saw the incidence of the disease reduced to "almost negligible conditions" within a shorter time than he had anticipated, and he believed he saw men who had been bed-ridden for months working in the fields again, and he thanked and acknowledged Sr. Arnolda's contribution in the most sincere words.[128]

# Conclusion

The rural health system based on the dispensary in the village of the Native Authority was limited and fragile. The dresser medical system in Ulanga District was, according to one observer, probably one of the "worst" in Tanganyika.[129] This chapter has shown that the system really did not addressing more than a limited number of health issues, and probably with a rather low 'biomedical' standard, as we found little trace of a preventive or sanitation regime implemented by the modern institutions. It is certainly hard to imagine that the practice of dispensary medicine could have established anything like a biomedical hegemony in the 1920s and 1930s.

The state medical services might have been conceptualized to cover the territory, as we have seen in chapter 2, but medically it delivered fragmentary services and the medicine practiced in the dispensaries was not consistent. The dressers and dispensaries differed in their abilities and 'specializations'. The dispensaries took niches and segments in the local medical marketplace. Therefore, it seems that from a medical point of view the dispensary system in Ulanga contributed more to 'medical pluralism' than to a hegemony of a biomedical episteme.

But even if medical practice in the dispensary was overtly fragile and if 'modern medicine' remained a slippery concept, it established a recognizable institutional presence of 'modernization' across the district. This institutional presence was built on a cohort of proto-professionals, the 'Dressers', who were to remain important health workers in Ulanga for decades, since the dispensary system was to be kept as the backbone of the biomedical system well into the post-independence era. Faced with the choice of dispensary medicine, locals learnt to take their own decisions as to whether and how one could rely on the services delivered at a Government Dispensary.

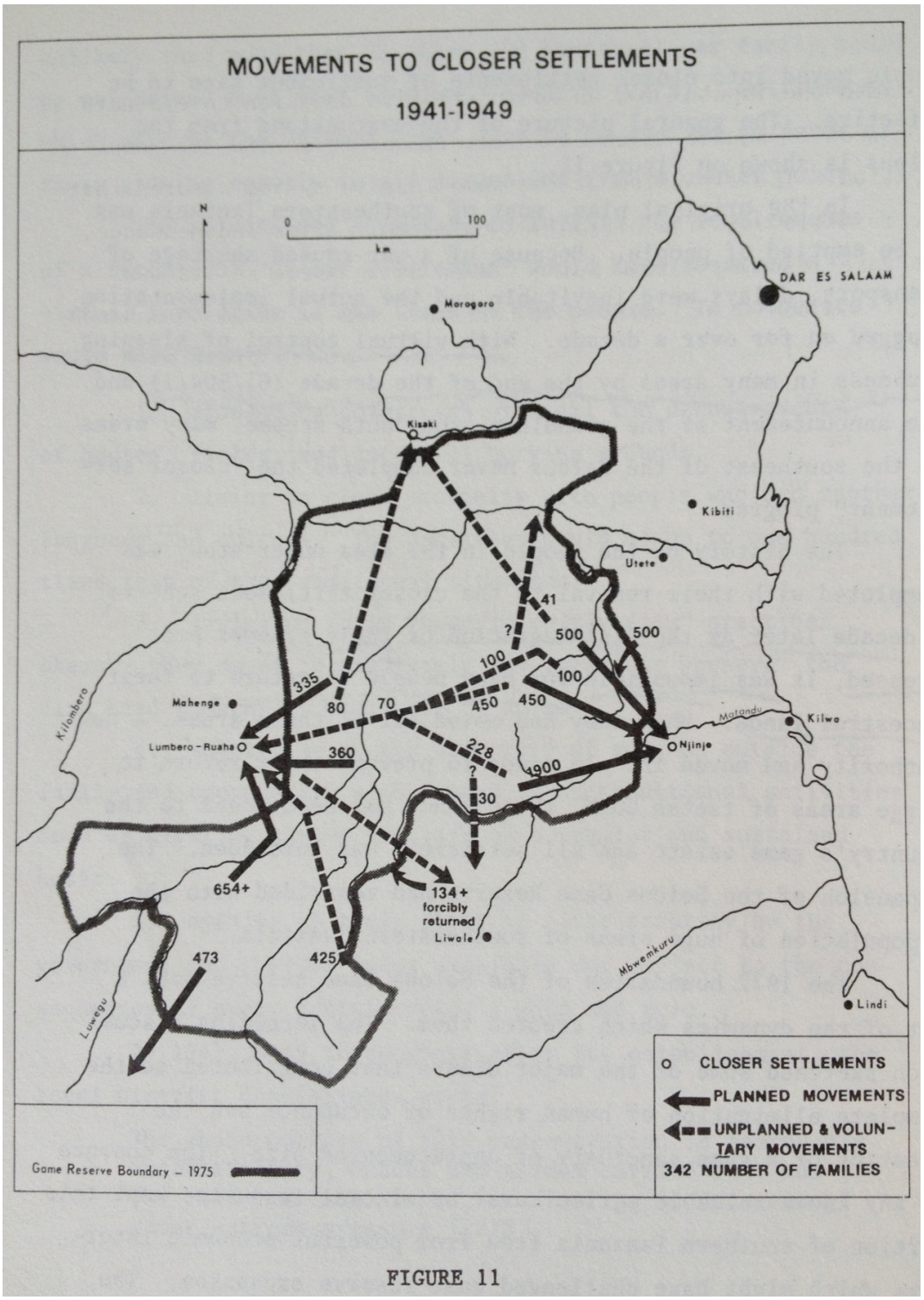
As the actual capacity of these institutions to deliver medical help remained quite low in the interwar period, mission medical services found a field where they could contest the state as pioneers of modernity and welfare. Often Mission institutions were considered to deliver better

[127] Scott felt that Culwick needed to be told to insist on pit toilets building. TNA 450/56: A. T. Culwick, *Letter to the Dir. of Medical Services. Kiberege 15.11.1935*.
[128] TNA 450/439 & 450/56: A. T. Culwick, *Letter to Dr. Scott. Kiberege 17.11.1935*.
[129] TNA 61/231G: E.C. Baker, *Letter PC E.P. to H., Fairbairn, Sleeping Sickness Officer, Tabora. DSM 19.09.1941*.

quality services. Mission dispensaries also provided a relatively large number of medical treatments. These dispensaries probably catered mainly to the missionary clientele, however. Anyway, as a general specialized medical infrastructure – in the form of dispensaries and not just the medicine chest of a missionary priest – Mission Dispensaries were few and far between. These institutions seem to have constituted a medical service somewhat apart, leaning towards the 'hospice and hospital' sector. This explains in part why the missionaries from Tanganyika stuck to the word 'hospital' even if the mission health post would not be considered as such in a European context.[130] More than just the nomenclature, however, the 'hospital' also laid claim to quality and institutionalized a form of medicine which targeted the patient as an in-patient under the constant supervision and intervention of the health professional.

It would, therefore, be wrong to conclude that medical care in rural Africa was left exclusively to the Mission, or that the missionaries were the sole pioneers of 'modern medicine'. In terms of the invention of a modern rural world, 'villages' were meant to contain a chief's *Baraza*, a market, schools and a dispensary. At a number of places however, in particular in Sofi and Ifakara, the Mission's services did out-pace N.A. medical services, both on the level of medical standards and in the number of treatments offered. When they found such open field, missionary institutions set new standards of biomedicine, especially in the way they encountered the 'patient'. First, however, we turn to the role of sleeping sickness in the history of 'development' in Ulanga.

[130] Note that it could nevertheless contribute to a skewed image in Switzerland of the African rural areas as being in need of only a sort of 'toy hospital' service.




Sleeping Sickness Concentration. Map from Matzke[1]

[1] G. E. Matzke, *Wildlife in Tanzanian Settlement Policy*, 1977, p. 44.

# Chapter 4 The Big Experiment: Scientific Reason and Development

In 1943 the priest at the mission station in Ruaha wrote a letter to a colleague in Switzerland and explained that in Ulanga he lived "in a time when everything in the world was topsy-turvy". His statement was not a comment on the World War situation, but reflected how Ruaha was in the midst of an area which had experienced "a veritable mass migration".[1] The reason for this migration was the intervention enforced by the colonial administration whereby the perceived need for control of sleeping sickness necessitated that people be moved closer together. In the name of health and development, thousands of Africans living in the valley in the south of Mahenge were relocated and "concentrated" into new settlements.

Based on these events, this chapter tells the story of the process by which the custodians of "knowledge" interacted with the Government. At the end of the period of austerity of the 1930s, the 'civilizing mission' was extended into a system of governance that was based on the practical contribution of 'science' towards bringing progress and welfare to life on all levels. It was the beginning of a new era of development. It witnessed many struggles amongst experts and it impacted heavily on the lives of those who were subjected to these schemes. In a new mode of administrative practice, the colonial government called upon a range of scientific bodies of knowledge in order to halt 'the demise' of rural African populations.[2] While this scientific knowledge became a guide for administrative and state activities, the African subject, his economy and his body came to be seen as in need of a concerted effort by modern sciences in order to produce his own future.

[1] P. Kosmas *Schlafkrankheit und Wandern [letter to Dekan Schnarwiler, Buttisholz. Igota, 15.10.1943]*, in Missionsbote der Schweizer Kapuziner in Afrika, 1944.
[2] Malcolm Hailey, *African Survey*, 1938; Frederick Cooper et al., *International Development - Introduction*, 1997; Frederick Cooper, *Writing the History of Development*, in Journal of Modern European History, 2010; Peter Pels, *Global Experts and African Minds*, in Journal of the Royal Anthropological Institute, 2011; Joseph Morgan Hodge, *Triumph of the Expert*, 2007; Helen Tilley, *Africa as Living Laboratory*, 2011.

The first part of the chapter discusses knowledge relating to Ulanga and its production in the form of science. Looking at the anti-Sleeping-Sickness activities, the second part of the chapter takes this knowledge back into the practice of governance and shows how it structured and legitimized a mode of operation for development activities. It describes the activities against Sleeping Sickness in Ulanga and offers an argument about the idea of a 'benign autocracy'. This was, in fact, a marriage of pastoral power and the cultural racism which pervaded development discourse at the time, which led to an expert-led transformation of the African subject and the social fabric of his life.[3] The section on Sleeping Sickness control takes off from an argument from the history of science, begun by Arnold (on epidemics as the bases of state building), by Farley (on the role of tropical medicine in the service of the empire) and by Mary-Inez Lyons (on Sleeping Sickness as the basis of rural health systems), to suggest, that Sleeping Sickness control in Ulanga historically joins with a new thinking about African health in the context of rural development.[4] Sleeping sickness was a trigger that could start off an entire machinery of scientific and administrative measures that entered economically and political marginal areas.[5] A 'circus' of experts, as it was called even at the time, combined knowledge and administrative practices across different colonial departments and even territories.[6] While scientific discourses were part of a process of networks that exchanged knowledge on an imperial level, this knowledge was at the same time produced in dense and localized configurations.[7]

In Ulanga the scientification of administrative discourse is linked to health and medicine in an extreme way. Combating Sleeping Sickness by modernizing rather than simply concentrating settlements was a way to bring progress through science and planning. Health legitimized administrative intervention in the name and with the tools of science and reconfiguration of settlement patterns, and 'concentration' then accelerated the process of institutionalizing social services in rural areas. In a very particular and encompassing articulation of what Lynn Schumaker calls "field sciences", Sleeping Sickness concentrations applied science in a "big experiment".[8] It was a public health experiment in the field, an intervention which combined political engineering with a scientific mode of operation.

Two of the main characteristics of science in the colonies at the time were the rise of fieldwork and the thinking in ecological models. Tropical medicine, and Sleeping Sickness

[3] Joseph Morgan Hodge, *Triumph of the Expert*, 2007; Michael Jennings, *Building Better People*, in Journal of Eastern African Studies, 2009. Jennings uses the term 'coercive utopia', borrowed from Zbigniew Brzezinski. I stick to Culwick's term 'benign autocracy' also because it catches the historical path, from which it grew. My chapter here extends Jenning's argument in that it tries to give the historical depth to his argument.
[4] David Arnold, *Medicine and Colonialism*, 1993; John Farley, *Bilharzia: A History*, 1991; Maryinez Lyons, *Colonial Disease*, 1992.
[5] This was an effect that went back to the turn of the century. Maryinez Lyons, *Colonial Disease*, 1992; Mari Webel, *Medical Auxiliaries*, in The Journal of African History, 2013, pp. 397-400; Mari K. Webel, *Borderlands of Research: Medicine, Empire, and Sleeping Sickness in East Africa, 1902-1914*, 2012, pp. 5-8.
[6] Kirk Arden Hoppe, *Lords of the Fly*, 2003, 11.
[7] Patrick Harries, *Butterflies and Barbarians*, 2007.
[8] Lynette Schumaker, *Tent with a View*, in Osiris, 1996. The 'huge experiment' is a quote from: TNA 461/27/1: Tanganyika Territory District Officer Ulanga et al., *Mahenge Division -Ulanga District Annual Report 1942*.

research in particular, was central for the development of ecological thinking.[9] Fieldwork that related the trypanosomiasis pathogen with its animal and human hosts, and, not least, with the habitat of these hosts was the key to new ecology-oriented approaches. Sleeping Sickness research and agricultural research came to overlap at a time when in agro-science studies, large fieldwork programs took off.[10]

One of those who produced scientific knowledge in the field, and the man behind the "big experiment", was the District Officer Arthur Theodore Culwick. Culwick considered himself to be, if not in the possession of a "powerful electric light", then at least as a bearer of a "candle of science".[11] As a figure, A.T. Culwick is a symbol of a change in the style of state and government in the 1930s and 1940s. With his wide-ranging educational background, he pushed science as a tool of governance. Eventually his scientific expertise was sidelined, and his career took an unsavory twist when he became a supporter of Apartheid racist authoritarianism in his later, post-Tanganyika life. In the 1930s and early 1940s, his portfolio of scientific interests was in many aspects a carbon copy of the scientific preoccupations which discussed African life and survival: anthropology, demography and nutrition. Engaging in the production of scientific research and descriptions of the District in which he also served as an administrative officer, Culwick fed new knowledge into the global scientific network.[12]

Culwick, born in 1905, had studied science and colonial administration ("the Tropical African Services Course") in Oxford, where his future wife, Geraldine Mary, trained in Anthropology, a subject he subsequently also added to his curriculum of studies, receiving his diploma in Anthropology with distinction.[13] For a District Officer it was quite the norm to have University training from Oxbridge from about 1926.[14] As an administrator Culwick spent more time in the Mahenge District than any other colonial service administrator.[15] Apart from some

[9] Helen Tilley, *Africa as Living Laboratory*, 2011, pp. 184-198, 216.
[10] On the history of Sleeping Sickness research as an ecological science see John Ford, *Role of Trypanosomiases*, 1971; Anthony M. Jordan, *Trypanosomisasis control and African rural development*, 1986, pp. 86-87. William Beinart et al., *Environment and Empire*, 2009, pp. 184-199; Helen Tilley, *Ecologies of Complexity*, in Osiris, 2004. Henrietta L. Moore et al., *Cutting Down Trees*, 1994. In his seminal study Steven Feierman has shown how programs of colonial agricultural modernization clashed with local knowledge in northern Tanganyika, unleashing political convulsions and struggles over healing: Steven Feierman, *Peasant Intellectuals*, 1990.
[11] A. T. Culwick et al., *Study of Population*, in The Sociological Review, 1938/39, p. 22.
[12] Veronica Berry, *Culwick Papers*, 1994. Between 1935 and 1944 Culwick (co-) authored more than a dozen scientific articles of substantial length, as well as a full book: A. T. Culwick et al., *Ubena of the Rivers*, 1935. From 1946-1950 Culwick co-authored a series of articles on Sleeping Sickness transmission, one of them in the Swiss Tropical Institute edited Acta Tropica: H. Fairbairn et al., *The transmission of the polymorphic trypanosomes*, in Acta Tropica, 1950.
[13] Veronica Berry, *Culwick Papers*, 1994, pp. 14-15. Juhani Koponen considers Culwick's study on population as the best at the time for Tanganyika: Juhani Koponen, *Population: a dependent variable*, 1996, pp. 32-33. There are two folders in Bodleyan Library in Oxford with fotos from Culwick's time in Kiberege, which I have not accessed: http://www.bodley.ox.ac.uk/dept/scwmss/wmss/online/blcas/culwick-at.html See list of Diploma Students on: http://web.prm.ox.ac.uk/sma/index.php/articles/article-index/344-oxford-diploma-students-1921-1945.html, last accessed 22.3.2014.
[14] Anthony Hamilton Millard Kirk-Greene, *Symbol of Authority*, 2006, pp. 11-12, on training courses pp. 42-59.
[15] TNA *District Book, District Office Mahenge, No.2/ section Administrative Staff*.

time away, mainly to do research in other parts of the country, Culwick served in Ulanga as an administrator from 1932 to the mid 1940s.

"Too much stress," Culwick wrote, "cannot, however, be laid on the necessity for ample field-work. Statistics cannot take its place."[16] He and his wife used observation in the field to produce new data for the statistics which lay at the base of state knowledge. Together with his first wife, he researched and published an ethnography of the Bena as well as a number of articles on diverse topics, from stone engravings, to hippo hunting, honey production, and to extensive studies population and nutrition in East Africa.[17] The range of disciplines and topics covered was substantial, more perhaps than the true scientific expertise he could claim. His 'science' was often of a kind of amateurism that was better versed in fieldwork, than in the state of the art of theoretical debate in a particular discipline. The Culwicks were eager collectors of data. Geraldine Culwick collected 2,300 "histories of women in the Ulanga Valley".[18] For a study on nutrition, they asked literate people in the district to keep diaries of their food consumption and in the process collected the data on "21,500 feeding-times".[19]

After his first years in Ulanga, a place considered in administrators' circles as something of a "penal settlement"[20], the Culwicks probably hoped for a second career in research.[21] With many new research initiatives starting in rural Africa at the time, the Culwicks probably tried to capitalize on these five years in the periphery and they got away from Ulanga for research purposes.[22] But they did not stick exclusively to their own field of study. The Culwicks also tried to make data collected by others applicable to Eastern Africa.[23] During their research sabbatical, they connected with some of the leading academic experts on nutrition in particular. After a visit to the famous research team of Platt in the Nyasaland protectorate, they felt "fired with enthusiasm by all we had learned there".[24] Geraldine Culwick later pursued her own research career as a fieldworker in one of the large-scale development projects in Eastern Africa, the Gezira scheme in the Sudan.[25]

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[16] A. T. Culwick, *A Method*, in The Journal of the Royal Anthropological Institute of Great Britain and Ireland, 1935, p. 194.
[17] Many of Culwick's publications can be found on jstor.org or in Veronica Berry, *Culwick Papers*, 1994. He also published in the Tanganyikan Notes and Records. The Wabena ethnography has hardly an footnotes, with the exception of the chapter on medicine. It was published in a large British publishing houses at the time, Allen & Unwin in London. Culwick also contributed a (quite reeling) paper to a series which included Monica Wilson, Audrey Richards, Max Gluckmann and others: A. T. Culwick, *Good out of Africa. A study in the Relativity of Morals*, 1943.
[18] A. T. Culwick, *Study of Sex-Ratio*, in Separatum and East African Medical Journal, 1937.
[19] A. T. Culwick, *Study of Factors*, in East African Medical Journal, 1938/1939, p. 71.
[20] E. K. Lumley, *Forgotten Mandate*, 1976, p. 113.
[21] On the character of the first tour as a 'field tour' see: Lynette Schumaker, *Tent with a View*, in Osiris, 1996, pp. 240-242.
[22] TNA 25552: A. T. Culwick, *Letter to the Under Secretary of State for the Colonies*.
[23] A. T. Culwick et al., *Nutrition and Native Agriculture in East Africa*, in East African Agricultural Journal, 1941.
[24] G. M. Culwick, *Nutrition in East Africa*, in Africa: Journal of the International African Institute, 1944, p. 403. Geraldine Culwick also states, that their research done on nutrition in Bukoba ("Nutrition and its context in Bukoba" printed as Part II in Berry 1994, p.) was written up "at the request of Dr. Platt". Margaret Read also belonged to Platt's research team. On Platt's research see B. S. Platt, *Aspects of nutritional research*, in British Medical Bulletin, 1944. Cynthia Brantley, *Feeding Families*, 2002. Platt was also read in missionary circles: N.N., *Soziale Faktoren in den afrikanischen Kolonien*, in Missionsärztliche Caritas, 1946.
[25] G. M. Culwick, *A dietary survey among the Zande of the South-Western Sudan*, 1950.

## The Colonial Science: Population, Nutrition and African Society

In their ethnographic study, "Ubena of the Rivers", which stands as a first and major cornerstone of their research career, A.T. and Geraldine Culwick ask in their last chapter where the Bena are heading: “quo vadunt”? Their ethnography was from the stance of academic observers but it also had political and moral overtones: if there was a moral question to ask whether a custom was "good or bad?" the answer had to be found in “the function of that custom in relation to survival.”[26]

The rural African world of the 1930s was endangered by 'culture contact' with the larger world. Speaking about Ulanga, A.T. Culwick wrote that "communities on the fringe of civilization are susceptible to swift and far-reaching change when the gates that held back the modernizing forces are gradually opened."[27] To be sure, even the most primitive tribes had come into contact with the outside world already: "a curious thing about these very primitive people is that in spite of their isolation, numbers of them have travelled far. Most of their headmen have been to the coast and are well acquainted with European ways."[28] A rural sociology written at the time, therefore included three categories, the 'untouched', those who had worked for years for 'the semi-educated native rice-buyer', and those 'within the sphere of European and Indian influence'.

> "The reader of this essay will no doubt have been struck by the fact that so many of the changes which we have studied are directly attributable to the presence, not of Europeans or Asiatic, but of their native employees, whose cultural similarity to the tribesmen enables them to exercise a powerful influence on native life."[29]

Both Culwicks had trained in Anthropology at Oxford. This diploma course was taught by three professors, the "Oxford triumvirate" who dominated anthropological teaching in Oxford from the early 1900s to the 1930s, consisting of a professor of Anatomy (Prof. Thompson), who taught physical anthropology, Henry Balfour of the Pitt Rivers Museum who taught material culture, and Robert Ranulph Marett, a specialist on Religious Studies and the most important teacher in terms of theoretical teaching in cultural anthropology.[30] All these British anthropologists at the time were influenced by the organic ideas of functionalism, which

[26] A. T. Culwick et al., *Ubena of the Rivers*, 1935, p. 413. Culwick was later given a place in a publication series of the Rhodes Livingstone Institute on this very issue: A. T. Culwick, *Good out of Africa. A study in the Relativity of Morals*, 1943.
[27] A. T. Culwick et al., *Culture Contact on the Fringe of Civilization*, in Africa: Journal of the International African Institute, 1935, p. 167.
[28] A. T. Culwick, *Ngindo Honey-hunters*, in Tanganyika Notes and Records, 1938.
[29] A. T. Culwick, *A Method*, in The Journal of the Royal Anthropological Institute of Great Britain and Ireland, 1935, p. 193.
[30] Peter Rivière, ed. *A history of Oxford anthropology*, 2007, pp 5, 27. The man who was probably closest to the Culwicks as a tutor was Tom Penniman. The Culwicks acknowledge his contribution to their book, as he read proofs, did the indexing and answered many questions the Culwicks asked during the research for the book. Penniman at that time had no permanent position as a teaching staff, but assisted many of the students: Peter Rivière, ed. *A history of Oxford anthropology*, 2007, p. 79fn23.

imagined society, to put it somewhat simplistically, as a quasi-biological system with different organs serving the basic needs of the tribal group and its individual member.[31]

While their anthropological studies in Oxford clearly influenced the Culwicks, their analysis would always have to draw from local perspectives. Chief Towegale was prime informant and critical discussant of the Culwicks' ethnographic work.[32] Although Culwick's relations with the missionaries were full of tensions (Culwick felt that they were overly conservative and brought a 'medieval' unscientific religious thinking to the Africans), the social and moral changes in society he witnessed were nevertheless influenced and propelled by the Christian missionary presence.[33] 'Detribalized' people were thus seen as the crucial factor in rural governance, as much in Ulanga as in Switzerland. From a Swiss view, deep rural life was mystified into a haven of peace, and a stronghold of conservative politics.[34] The Swiss missionary, Veit Gadient, saw the problem of social dislocation and proletarianization bringing about communism as a serious threat in East Africa in 1934. Consequently, an investment in the African people was justified.[35] This new focus that made interventions into rural society necessary grew quite explicitly from the fears of urbanization, especially in a place like Tanganyika whose role in the imperial system was that of an exclusively agricultural producer.[36] In order to mitigate the destructive forces of rapid urbanization, the rural communities had to be developed, and interventions had to be made viable.

The Culwicks' functionalism was not freezing the tribal tradition. On the contrary, their book explicitly was not about salvage anthropology, but about the "tribe as it is today", facing 'readjustments' just like "the people in the valleys of South Wales did".[37] One can find three aspects of modernization that were discussed in this chapter, all of them tied to biopolitics: the *pax britannica* and its contribution to physical survival; polygamy, fertility and the women's

[31] Paul A. Erickson et al., *A history of anthropological theory*, 2013, pp. 91-93. "living organism" was a term used by Meyer Fortes and Evans-Pritchard in their African Political Systems: Carola Lentz, *Meyer Fortes/Evans-Pritchard: African Political Systems*, 2001, p. 107, p. xxii in the 1940 original book.

[32] He contributed a historical chapter to Ubena of the Rivers. Pels describes the method of doing anthropology on the Baraza, which produces data in relation in current public social affairs rather than life as lived in a participant observation: Peter Pels, *Global Experts and African Minds*, in Journal of the Royal Anthropological Institute, 2011.

[33] A. T. Culwick, *Good out of Africa. A study in the Relativity of Morals*, 1943, pp. 16, 25. Culwick's real-life relationships with the missionaries were varied. In Ifakara, his return to the District in the late 1930s was not seen as a positive development, but Culwick also had positive interactions with missionary staff, especially when material rural development was in question. He felt that the mission was not striving hard enough to modernize agricultural production, with exceptions, notably Fr. Kunibert Lussy at Ruaha. I thank Lukas Meier for this reference to a letter by Culwick to the PC EP, 01.12.1941. PAL 1057.J. Ifakara / Briefe: H. Schildknecht: Hieronymus Schildknecht, *Letter to E. Maranta. Ifakara 10.09.1939*.

[34] Roger Sablonier et al., *Die alte Schweiz als "Bauernstaat"*, 1991.

[35] P.V., *Eine harte Frage: Sind sie's wert?*, in Missionsbote der Schweizer Kapuziner in Afrika, 1934.

[36] Andreas Eckert, *Exportschlager Wohlfahrtsstaat*, in Geschichte und Gesellschaft, 2006, pp. 476-479. Joseph Morgan Hodge, *Triumph of the Expert*, 2007, pp. 187-189. Lynette Schumaker, *Tent with a View*, in Osiris, 1996.

[37] Dudley Buxton, *Introduction*, 1935, p. 8. Buxton was a physical anthropology reader at Oxford, who worked in "functional anthropometrics" in the Pitt Rivers Museum, but also had a great interest in folklore and local history. Alison Petch, "Measuring the Natives: Beatrice Blackwood and Leonard Dudley Buxton's work in Oxfordshire," *website adaption from History of Anthropology Newsletter, 35: 1 July 2008.* (2008), http://web.prm.ox.ac.uk/sma/index.php/articles/article-index/364-blackwood-dudley-buxton-and-otmoor.html. For their studies on population, the Culwick chose villages 'rather' than 'tribes' as their unit for research. Veronica Berry, *Culwick Papers*, 1994, p. 39.

question; and moral economy, welfare and social health in the kinship group.[38] On the third of these topics, the Culwicks stated:

> "In times of real want, however, a man needs something more nourishing than faith and hope and the will to live. He must have food, and he must have it at once. In other words, he requires the help of his more fortunate relatives and friends till such time as his renewed efforts bear fruit, rewarding his faith and justifying his hope. Previous chapters have shown how this need is met in Ubena, and we need not therefore enlarge here on the subject except to stress the psychological value of the Bena system of mutual help. This system, in which religious, social, and economic ties all have a part to play, is the native's insurance policy against misfortune, and is one of the most valuable features of the whole tribal system. Without it there would be no security, life would become one long fear for the morrow. The effect of anxiety of this type is well known, a certain amount spurs a man on to greater effort, but an excess depresses the spirits and takes all joy out of life."[39]

This psychological perspective on of modern life reflected a theoretical strand in the Culwicks' Oxford training.[40] But in their early work it did not translate into an afro-pessimist tone. Rather, the Culwicks saw "great plasticity" in the tribal institutions and "confidently look forward" that the Wabena will evolve and "meet modern needs."[41] This optimistic outlook changed considerably over the next couple of years, however. Still looking at the same topics, the Culwicks started to fall in with alarmist discourses about population decline.[42] From a long and complicated calculation based on "biological measuring as opposed to a mere counting", Culwick came to forecast that "the population will diminish at the alarming rate of at least 27 per cent in each generation unless conditions change."[43] Belonging to a cohort of anthropologists-administrators Culwick thought the state needed to know the facts about population trends.[44] The data from the government census, he contended, had been misleading however, and now there was an "immediate need for thorough investigation followed by well-planned and determined action ..."[45] Subsequently, Culwick identified two major issues which endangered the African population in its 'survival': Nutrition and the disintegration of authority (including kinship institutions) in African society.

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[38] See also Thomas Spear, *Indirect Rule*, 2005, p. 81.
[39] A. T. Culwick et al., *Ubena of the Rivers*, 1935, p. 418.
[40] Especially in the teachings of R.R. Marett: Martin Riesebrodt, *The promise of salvation: a theory of religion*, 2010, pp. 57-60. Paul A. Erickson et al., *A history of anthropological theory*, 2013, p. 91. But only limited impact on the development of theory: Peter Rivière, ed. *A history of Oxford anthropology*, 2007, pp. 55-57. On Maretts larger impact on religious studies Hans G. Kippenberg, *Robert Ranulph Marett*, 2001.
[41] A. T. Culwick et al., *Ubena of the Rivers*, 1935, pp. 66, 419.
[42] Rivers was at the time making an argument about the "psychological roots of de-population", see: Erwin H. Ackerknecht, *In memory of William H.R. Rivers, 1864-1922*, in Bulletin of the History of Medicine, 1942.
[43] A. T. Culwick et al., *Study of Population*, in The Sociological Review, 1938/39.
[44] A. T. Culwick, *The population trend*, in Tanganyika Notes and Records, 1941. Culwick wrote: "The anthropologist can help the administrator by outlining the general principles of social change in certain conditions and by showing where strain and disintegration are likely to occur, but it is only the administrator with his local knowledge who can weigh up the personalities and gauge the effect of the human factor in any given case." A. T. Culwick et al., *Culture Contact on the Fringe of Civilization*, in Africa: Journal of the International African Institute, 1935, pp. 169-170. The review of their book was written by a fellow DO-Anthropologist, Bruce Hutt, who was stationed in Iringa and authored a book collectively with an academic anthropologist, in which they tried to make anthropology relevant for state action G. G. Brown et al., *Anthropology in Action*, 1935; Bruce Hutt, *[Review:] Ubena of the Rivers*, in Africa, 1936; Peter Pels, *Global Experts and African Minds*, in Journal of the Royal Anthropological Institute, 2011, pp. 794-796. Hutt's review in parts is a plagiarism of the postscript of the book.
[45] A. T. Culwick et al., *Study of Population*, in The Sociological Review, 1938/39.

The debate amongst historians about demographic development in Eastern Africa shows how complex it is to understand changing patterns of settlement, fertility and mortality. The question of demographics has vexed the mind of colonial administrators and rulers throughout the 20th century. Demographics and statistics are central tenets of the modern state, and the keepers of states have been preoccupied with the specters of under- and overpopulation.[46] We need not even look at the German obsession with the "Volk" to find examples of depopulation panic in the 1930s, as Britain and Switzerland stood alongside Africa in these times of population scares.[47] Nancy Hunt described how in the Congo, local depopulation scares found ritual expressions amongst Africans at the time.[48]

Nutrition and fertility were the key factors in need of scientific knowledge identified by the Culwicks. Famine had been a problem in the 1920s already. But famine as starvation was quite different from malnutrition as a problem that affected the health and therefore the productivity and fertility of a society. Michael Worboys has argued that "the 'discovery' of colonial malnutrition [in the interwar period] was a result of the direct transfer of the 'dietary survey' from the centre to the periphery." This meant that famine and hunger was not seen as a result of colonialism. African 'ignorance' was the major problem.[49] In Tanganyika from the early 20th century, colonial doctors, sometimes informed by missionaries, saw 'ignorant' African practices as the root cause for a diminishing population in the colonies.[50] But whilst historians today might differ about the level of mortality in pre-colonial times and about the exact interplay of capitalist expansion, colonial brutality and emerging disease patterns, they nevertheless agree that African 'behavior' was not the root cause of diminishing health and population in the time up to about 1940.[51] As children of their time, the Culwicks, however, were engaged in this global debate central to the empire, a debate about diminishing population, and a dysfunctional African (cultural) behavior. For the Culwicks, too, the fault lay with the "native":

> "There is a very large economic problem of supply, but there is an even larger educational problem behind it [...] the crux of the whole matter is education in the broadest sense [...] the native's complete lack of understanding of the most elementary principles of nutrition."[52]

Culwick's reports on population and nutrition provoked a small but enlightening debate on the role of education and health for the development of rural Africans. The colonial

[46] Thomas Etzemüller, *ewigwährender Untergang*, 2007. Joseph Morgan Hodge, *Triumph of the Expert*, 2007, pp. 121-124; Daniel Bendix, *Colonial Fear of Underpopulation*, in Global South (sephis e-magazine), 2010. In the early 20th century German colonial officials were more pre-occupied with population than their British counterparts: Juhani Koponen, *Population: a dependent variable*, 1996, p. 21.
[47] Karl Ittmann, *Colonial Office and the Population Question*, in The Journal of Imperial and Commonwealth History, 1999. P. 57 Wilhelm Bickel, *Bevölkerungsgeschichte*, 1947, pp. 176-178.
[48] Nancy Rose Hunt, *Rewriting the Soul in a Flemish Congo*, in Past and Present, 2008, pp. 188-189.
[49] Michael Worboys, *Discovery of Colonial Malnutrition*, 1988, pp. 222-223. But see for South Africa: Diana Wylie, *Starving on a Full Stomach*, 2001.
[50] Stacie Colwell et al., *Infant and Child Mortality on Kilimanjaro, 1894-1935*. Otto Peiper, *Sozial-medizinische Bilder aus Deutsch-Ostafrika*, in Zeitschrift für Säuglingsschutz, 1912. J. M. M. van der Burgt, *Zur Entvölkerungsfrage Unjamwesis und Usumbwas*, in Koloniale Rundschau, 1913.
[51] Stacie Ann Colwell, *Vision and Revision*, 2001. Matthew Lockwood, *Fertility and Household Labour*, 2001, pp. 24, 26-28.
[52] A. T. Culwick, *Study of Factors*, in East African Medical Journal, 1938/1939, p. 73.

administrators agreed that development could be accelerated by education. The lack of scientific knowledge was identified as a problem by the Culwicks but, with the means of propaganda, Africans could be "convince that his body needs a varied diet" [53] Health and education, according to the Provincial Commissioner, was now seen as a precondition for an upward spiral:

> "I am inclined to think that the first step is in the direction of improving the physical well-being of the people and affording educational facilities [...] so that people may be fitter for increased physical effort in the matter of agricultural production followed by increased wealth after which will follow the desire for improved living conditions."[54]

Development was presented as an opposite process to a "vicious cycle [...] of low economic ['capacity'?], malnutrition and ill health."[55] The acting District Officer in Ulanga, T.O. Pike, leveled serious criticism at Culwick's methodology and disputed the existence of exceptional levels of malnutrition in his district. He did, however, agree that ill-health was a serious obstacle to economic development because diseases like "hookworm, malaria, hernias and yaws are rampant in Ulanga and attack the strong as well as the weak." "The result," he continued, was "that the productive capacity of many of the best labourers is greatly impaired."[56] Such a take on development was based on a total view of society. But in their assessment of the general state of the district the colonial officers differed. Pike saw the people in the district labouring hard, he perceived progress and he spoke against population concentration ("closer settlement") and for shifting cultivation. He warned that "under present conditions to try to anchor the native to a particular plot on sub-marginal land would merely mean tribal suicide."[57] Pike's optimistic outlook on the district was later criticized by Culwick: "I confess I do not share the optimism which some of my predecessors have shown in their annual reports on this division", Culwick wrote when he came back in to the district.[58]

## Sleeping Sickness in Ulanga

It was exactly when Culwick returned to Kiberege at the end of 1939 that Sleeping Sickness started to be seen in Ulanga. Roughly two cases were being diagnosed each month in the area of Mgeta in the southernmost parts of the district. In parts of the district to the south of Mahenge things did not look better. An African hospital assistant, Thomas Chirwa had found cases of Sleeping Sickness there as well.[59]

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[53] TNA 25838: *Note adressed to Mr. Arundell, 24.06.1938*; TNA 25838: R.R. Scott, *Letter by DMS to Chief Secretary, 11.03.1939*.
[54] TNA 25838: W.S. Marchant, *Letter by PC EP to Mr. Arundell, DSM, 27.01.1939*.
[55] TNA 25838: R.R. Scott, *Letter by DMS to Chief Secretary, 11.03.1939*.
[56] TNA 25838: T.O. Pike, *[Comments on Culwick, A.T.: A study of factors governing the food supply in Ulanga]*.
[57] TNA 25838: T.O. Pike, *[Comments on Culwick, A.T.: A study of factors governing the food supply in Ulanga]*.
[58] TNA 461/27/1: Tanganyika Territory District Officer Ulanga et al., *Annual Report. Mahenge Division of Ulanga District. 1941*.
[59] TNA 61/129H: *A report on Sleeping Sickness in the Ulanga District. [probably by G. Maclean]*. H. Fairbairn, *Sleeping Sickness in Tanganyika Territory, 1922-1946*, in Tropical Diseases Bulletin, 1948. The missionary doctor Alois Gabathuler claimed to have diagnosed the first cases: PAL Sch 1061.5 Mappe 3 darin "tempus 1939": Alois W. Gabathuler, *Letter to E.*

The history of Sleeping Sickness in Eastern Africa is a searing one. The type of pathogen in Eastern Africa is particularly aggressive on human life.[60] As were the colonial interventions, when they came as a combination of vicious attack on the trypanosome in the body and also on settlement structures and the social fabric of the African society.[61] John MacKenzie has brought up Sleeping Sickness as an "intriguing case-study in imperial science".[62] Many historians have followed since and contributed to make Sleeping Sickness probably the most prominent disease in the historiography of health and medicine in (East) Africa.[63] Sometimes it almost seems as if Sleeping Sickness is the Big Bang theory of the history of biomedicine in Africa.[64] Certainly, not least, thanks to John Ford's account, the study of Sleeping Sickness has helped historians to understand disease in African history from an ecological perspective, and to acknowledge the complexities of African systems of controlling such disease ecologies. There is no question that in the period under discussion African social control over the environment weakened.[65] The debate on "colonial intrusion and disease" (as Beinart and Hughes called the revisionist argument of historians who propose that, unlike stipulated by colonial experts, the *pax britannica* exacerbated the Sleeping Sickness situation) is not in the focus of my chapter here.[66] It is clear, however, that Sleeping Sickness was tied in with development. How much this was the case can easily be grasped from the analysis Helen Tilley provides on the Colonial Development Act funds: Sleeping Sickness projects consumed the majority of these funds, especially in Tanganyika.[67]

According to numbers collected by Kjekshus, total populations of roughly 13,500 people were moved in Southern Ulanga District in 1941 and 1942, and a total of 26,000 were moved by 1945.[68] In the neighboring parts of the Liwale district, roughly 30,000 people were resettled in

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*Maranta. Mahenge 23.10.1939*. TNA 26367: Alois W. Gabathuler, *Letter to Dir. of Medical Services DSM, Mahenge 12.07.1945*.

[60] John Ford, *Role of Trypanosomiases*, 1971.

[61] Eleanor Fisher et al., *Spectacle of Modernity*, 2000, p. 86-87.

[62] John M. MacKenzie, *Experts and Amateurs*, 1990, p. 189.

[63] Most recently Deborah Joy Neill, *Networks in Tropical Medicine*, 2012. Neil took up Worboys' finding about the different approaches to Sleeping Sickness in different colonial traditions. She looks at Sleeping Sickness before the period discussed here, but carves out how national and transnational networks of tropical medicine developed around this particular disease. Michael Worboys, *Comparative History of Sleeping Sickness*, in History of Science, 1994. For a very different, more African social history grounded, perspective see Mari Webels 2012 thesis from Columbia University: "Borderlands of Research: Medicine, Empire, and Sleeping Sickness in East Africa, 1901-1914."

[64] Maryinez Lyons, *Colonial Disease*, 1992. Also Carol Summers, *Intimate Colonialism*, in Signs, 1991, p. 789.

[65] James Leonard Giblin, *Trypanosomiasis Control*, in Journal of African History, 1990; Helge Kjekshus, *Ecology Control and Econonomic Development*, 1977; John Ford, *Role of Trypanosomiases*, 1971.

[66] William Beinart et al., *Environment and Empire*, 2009, p. 192. The argument was started by: John Ford, *Role of Trypanosomiases*, 1971, pp. 8, 488-494.

[67] Helen Tilley, *Africa as Living Laboratory*, 2011, pp. 175-179.

[68] Helge Kjekshus, *Ecology Control and Econonomic Development*, 1977, p.172. H. Fairbairn, *Sleeping Sickness in Tanganyika Territory, 1922-1946*, in Tropical Diseases Bulletin, 1948, p. 8 table 1. By 1943 the resettlement of Mchanganyi, Lupiro and Iragua was almost completed. For 1944 Itete, Mtimbira and Sofi were planned to be concentrated and then "the whole of the Mahenge Division of the Ulanga District will have been dealt with". Mofu, Mbingu und Mgeta were also concentrated during the war years: TNA 461/10/14: *file: Kiberege Concentration General*. In the northern (Kilombero) division of the District, resettlement activities would go on much longer.

the same period.[69] Even if the sheer force of the resettlement was mediated by an amount of arbitration by Native Authorities, the reporting officer was well aware that "there is no doubt that compulsion will have to be used in many cases."[70] It is not possible to describe in detail here how the people suffered who went through this exercise of moving, building, hoeing, planting, harvesting and living together in new settlements.

When first reports about Sleeping Sickness in the southernmost corner of Mahenge district started coming in, George Maclean, the Tanganyika Territory Sleeping Sickness specialist, was called to do a tour in order to establish the situation. Maclean found two cases.[71] In 1940, 76 cases of sleeping sickness with 12 deaths were reported for the Mahenge section of Ulanga, and a total of 102 for the entire district.[72] It soon became clear that Sleeping Sickness had been brought into the district but that the patients diagnosed in Ulanga seemed to have contracted the diseases in their home areas, not in transit for labour migration. Action was to be taken. In a separate document from the same visit, Maclean suggested that “three or four dressers should be selected for special training in the diagnosis and treatment of sleeping sickness and yaws”.[73] The administrators considered it urgent to act and quickly posted a well-trained dresser at Mgeta.[74]

## Concentrated settlement

Maclean's report also made a recommendation to plan re-settlement measures in order to contain Sleeping Sickness: "If [the report on Chief] Mponda's area is confirmed, the people should be concentrated at the same time as concentrations are carried out in the Liwale district” the area neighbouring Ulanga to the south.[75] The strategy of concentration was based on ecological thinking. Concentrated settlement would break the cycle of the tsetse infestation by establishing permanent clearings around human settlements, even if only a small number of people lived in an area. The aim was to reach a scientifically determined population density. The process was to be achieved through estimations of population, agricultural survey, assistance to transport, clearing and building. Even the best means of transport, a 15-ton-diesel-engine road

[69] Thaddeus Raymond Sunseri, *Wieding the Ax*, 2009, p. 110. G. E. Matzke, *Wildlife in Tanzanian Settlement Policy*, 1977, pp. 41-45.
[70] TNA 461/27/1: Tanganyika Territory District Officer Ulanga, *Annual Report. Mahenge Division of Ulanga District. 1940*.
[71] TNA 61/129H: *A report on Sleeping Sickness in the Ulanga District. [probably by G. Maclean]*. A total of eight cases are noted for Mahenge in 1939 in: H. Fairbairn, *Sleeping Sickness in Tanganyika Territory, 1922-1946*, in Tropical Diseases Bulletin, 1948, p. 17 appendix 11.
[72] H. Fairbairn, *Sleeping Sickness in Tanganyika Territory, 1922-1946*, in Tropical Diseases Bulletin, 1948, p. 17 appendix 11. TNA 461/27/1: Tanganyika Territory District Officer Ulanga, *Annual Report. Mahenge Division of Ulanga District. 1940*.
[73] TNA 61/129H: George Maclean, *Notes on Ulanga District [recieved 18.01.1940]*.
[74] TNA 61/3/xiii/H: A. T. Culwick, *Monthly report for the month of January 1940. Kiberege Division. Ulanga District*; TNA 61/3/xiii/H: A. T. Culwick, *Monthly report for the month of Feburary 1940. Kiberege Division. Ulanga District*; TNA 61/3/xiii/H: A. T. Culwick, *Monthly report for the month of March 1940. Kiberege Division. Ulanga District*; TNA 461/27/1: Tanganyika Territory District Commissioner Ulanga et al., *Annual report for the year 1940 Kiberege Division, Ulanga District*; TNA 61/3/xiii/H: W. Wenban-Smith, *Monthly report for the month of April 1940. Kiberege Division. Ulanga District*.
[75] TNA 61/129H: *A report on Sleeping Sickness in the Ulanga District. [probably by G. Maclean]*. In practice, Liwale would be resettled somewhat later. On Liwale see Thaddeus Raymond Sunseri, *Wieding the Ax*, 2009, pp. 108ff.

train, was devised by the specialists. Not the least part of the scheme was to "bring educational, medical and other facilities to the people and lead to better health and greater prosperity."[76]

The policies of closer settlement in Ulanga go back to the early 1920s. Although little is known about these activities, they were mainly intended to ease the task of administration and were enforced with a considerable amount of vigorousness, according to Lorne Larson. At that time, the amelioration of health was an argument used, but it was one that sparked off little effective activity.[77] When Culwick arrived in Ulanga for the first time, he quickly subscribed to an agenda of closer settlement. Indirect rule demanded that populations were stabilized under 'their chief'. Culwick claimed to have learnt about the theme of closer settlement in his consultations with Chief Mkalimoto who "recommended that the people be gathered together into several large villages, so laid out as to provide the maximum protection from game."[78] Culwick supported these chiefs who "felt that if the district is to go ahead it is essential to control this movement of natives, and have on my advice issued an order prohibiting any native to move his house without first obtaining the sanction of the Native Authority." "This order," Culwick added at the same time as he was pursuing his anthropological research, "is strictly in accordance with the tribal custom."[79]

At that time, Culwick seems to have enforced this kind of chiefly control "against government policy", as a note on the document highlighted.[80] If that was so at all, it did certainly not mean that Culwick did not receive support from the administration for his plans. The Provincial Commissioner advised Culwick how to proceed:

> "I would suggest to you that you should concentrate your efforts on the more intelligent men of the tribe and explain to them the advantages of congregating in villages. If you could succeed in getting one such village going, it would serve as an object lesson and would probably lead eventually to the more wayward members taking to village life. Constant and sustained propaganda on these lines should be undertaken. Any success in this direction is more likely to be permanent than forced concentration, which have never been satisfactory in my experience."[81]

This piece of advice shows that more than chiefly initiative was at play. Had population concentration measures under the District Officer Lumley mainly been argued as crop protection from game, Culwick and especially his short-lived predecessor as a District Officer, Rooke Johnston, now introduced a broader aim for closer settlement. They set closer settlement into a perspective of rural development.[82] Rooke Johnston, then newly posted in the Ulanga

[76] J.F. Corson, *[Review]: Fairbairn, H.: Agricultural Problems*, in Tropical Diseases Bulletin, 1944; H. Fairbairn, *Sleeping Sickness in Tanganyika Territory, 1922-1946*, in Tropical Diseases Bulletin, 1948, pp. 6-8.
[77] Lorne Larson, *History of Mahenge*, 1976, pp. 222-224. Larson suggests that the health argument was only a means to prevent criticism from the League of Nations or others, see his note 11 on p. 223.
[78] TNA 61/341 H: A. T. Culwick, *Letter A.D.O. to PC EP. 08.02.1933*. Later knowledge on Sleeping Sickness was coproduced by the local chiefs, see Ollendorf writing on the 11.05.1943 in: TNA 461/10/14: *file: Kiberege Concentration General*.
[79] TNA 61/341 H: A. T. Culwick, *Letter A.D.O. to PC EP. 08.02.1933*.
[80] TNA 61/341 H: A. T. Culwick, *Letter A.D.O. to PC EP. 08.02.1933*, note on document.
[81] TNA 61/341 H: *Letter PC EP to ADO Kiberege. 18.03.1933*.
[82] TNA 461/27/1: Tanganyika Territory District Commissioner Ulanga et al., *Annual report for the year 1940 Kiberege Division, Ulanga District*; E. K. Lumley, *Forgotten Mandate*, 1976, p. 135.

district, saw Ifakara as a model settlement, and he wished "to see each area with its population collected together in similar villages."[83] The Wandamba in the river flood area of Kilombero to him were "very individualistic" people, and "their agriculture will require more careful development."[84] Rooke Johnston also spoke about the "Southern wilderness", the valley to the south of Mahenge. There the planned resettlements were "a new departure in concentration, in that the people to be concentrated will be leaving their own tribal area for that of another chief, but it is intended that they shall keep their separate entity."[85] This was indeed a new departure from the earlier attempts by Culwick to support chiefs' hold over their population by bringing people closer to the chiefs' places. This new departure to enforce tribal organization was now not only a result of the blinding effect the duties associated with Indirect Rule had on many administrators in Southern Tanganyika.[86] It was an explicit turn to rearrange populations. It was also an act of Indirect Rule despotism or, as A.T. Culwick termed it later, an act of 'benign autocracy'.[87]

A.T. Culwick was the man actually overseeing the resettlements in most of Ulanga. He was eager and driven to intervene. He saw his earlier (from about 1936[88]) fears about the arrival of Sleeping Sickness corroborated and was very nervous about the state and social development of the district. Hardly had he arrived as a District Officer in Mahenge that he made the cotton inspector his proxy, so that he himself was freed to go down to the Ruaha area to take care of the concentration.[89] But Culwick's approach was more welfare and development oriented than Rooke Johnston's take on the situation and Culwick also might have been different in the extent to which he embraced medicine and science. He came back from a time in the medical administration in Dar es Salaam where he probably picked up some of the Medical Officer's and Sleeping Sickness specialists views on the aims and management of concentration (and he would later go on to research Sleeping Sickness in the laboratory).[90] Besides, his reading of anthropology led him to seize on welfare as a tool to reinforce the social body of the African. Culwick detected an "almost complete breakdown of authority" in the district and he felt that social stability was to be guarded by supporting 'traditional' rule:

> "Even fathers are powerless in the face of opposition from their wives and children [...and] the tendency is [...] for the people of a good headman to diminish and for those of a slack one

[83] TNA 461/27/1: Tanganyika Territory District Commissioner Ulanga et al., *Annual report for the year 1940 Kiberege Division, Ulanga District*.
[84] TNA 61/68H: *Letter probably by PC E.P to Chief Secretary. 28.04.1944*.
[85] TNA 461/27/1: Tanganyika Territory District Officer Ulanga, *Annual Report. Mahenge Division of Ulanga District. 1940*.
[86] James L. Giblin, *History of the Excluded*, 2005, pp. 56-57.
[87] In 1944 Rooke Johnston was Provincial Commissioner and at the head of the resettlement campaigns in Liwale, which he wanted to "eliminate".Thaddeus Raymond Sunseri, *Wieding the Ax*, 2009, p. 108. On 'benign autocracy' see further down in this chapter.
[88] TNA 461/10/14: A. T. Culwick, *Letter to PC, Mahenge 16.02.1942*.
[89] TNA 461/27/1: Tanganyika Territory District Officer Ulanga et al., *Annual Report. Mahenge Division of Ulanga District. 1941*.
[90] Culwick later worked with Maclean's colleague as a Sleeping Sickness specialist in Tanganyika, H. Fairbairn. His influence on Culwick's understanding of concentration was not assessed, but Fairbairn certainly did not work against Culwick's interests and will in 1941.

> to increase. But the disastrous result of our policy on granting the native complete freedom of movement do not stop there. If a father rebukes his son, the latter will frequently walk straight out and go to Kilosa or Ifakara, leaving his aged parents to fend for themselves, and returning impenitent, and often diseased, for the harvest in which he expects to share, and unfortunately invariable does. Even when there has been no quarrel, hordes of young men go off toward the end of the year to the sisal estates, or to other employment, to avoid having to cultivate food crops at home, and stay away until the harvest has been gathered [...] So long as the native is granted a degree of freedom out of all proportion to his sense of responsibility, so long will this division be riddled with preventable disease, poverty-stricken, undernourished and undisciplined."[91]

## A practice of rural development

Based on this perception of the state of society, Culwick was thus trying to re-create a sort of 'traditional' African society with the help of welfare, medical services and the modernization of administration. It needed, however, sustained financial support: the settlements would need years of sympathetic "after care". A long investment in assistance was needed because, "it has been long recognised by thinking men and women that no poverty-stricken and degraded population, such as we have here, can ever raise itself without outside financial assistance."[92] But if financial assistance and modern scientific knowledge could prevent disease and malnutrition, it would not help as long as people had the right to make decisions on their own. This was a field where state authoritarianism was meant to bring development. In Culwick's eyes it was almost meant as a tool to assist African society to become functional again. Authority was to be coupled to experimental intervention. To Culwick, the resettlements were a big experiment in bringing health to the district:

> "It is an experiment in the feasibility of freeing half the division from the threat of Sleeping Sickness and providing it with sufficient food, cash, communications and medical facilities at a cost within the capacity of Government to bear." [93]

It is important to note that Culwick did not develop Ifakara, the trade centre with Indian and European populations, into a model village of development; the African Sleeping Sickness concentrations were in the Ruaha and Luhombero plains. These settlements were meant to be paying "a dividend in health and prosperity [...]. This economic and social revolution has been watched with keen interest by the rest of the division, and much propaganda in favor of closer

[91] TNA 461/27/1: Tanganyika Territory District Officer Ulanga et al., *Annual Report. Mahenge Division of Ulanga District. 1941*. For a similar argument on women opposing patriarchal control, and mission adherents opposing chiefly power: E. K. Lumley, *Forgotten Mandate*, 1976, pp. 164-165.
[92] TNA 461/27/1: Tanganyika Territory District Officer Ulanga et al., *Mahenge Division -Ulanga District Annual Report 1942*. This reflects a change of development thinking in the empire. Hailey called on the British people "to be more liberal in our attitude to the need for financing colonial development [...]".Lord Hailey, *Some Problems Dealt with in the "African Survey"*, in International Affairs, 1939.
[93] TNA 461/27/1: Tanganyika Territory District Officer Ulanga et al., *Mahenge Division -Ulanga District Annual Report 1942*.

settlement has been generated, not by the staff, but by natives passing backwards and forwards on various errands."[94]

In the resettlement campaign, the District Officer changed from tax-man to development worker. District Officers sought this role: "Far too much time and effort has to be devoted to wringing the last cent from the population," an officer wrote from Ulanga in 1940, and continued that this time and effort "could be better employed in an effort to raise the standard of living conditions."[95] It was a type of expert who not only surveyed and advised as a consultant, but also guide and implement as a project director. What emerges in this administrative ideal is a number of elements, experimental pilots and long-term financial assistance, which are part of a development regime, rather than of an economic policy of primitive colonial extraction.

## Health and Resettlement: Ruaha Area

Ruaha lies in a large alluvial valley, from Kwiro/Mahenge requiring two hours of travel by foot downhill and southwards. Since 1928, Ruaha was also a Catholic parish, the missionary centre of a large part of the valley.[96] The Mission used schools as an instrument what they felt was a Muslim encroachment in the valley.[97] Another instrument was health care. According to the recollections of a missionary:

> „So many came to see me, workdays or Sundays, and all wished to receive something from my magic chest, a small travel pharmacy. One wanted some quinine against fever, another one ointment to treat his wounds, a third one some drug against abdominal pain etc and almost everyone took along a healing word or a patch against the diseases of the soul. Another one arrived, opened his cute mouth and presented one or another villain causing too much pain. So I took the beautiful tongs my cousin, who was a dentist, had sent to me in order to relieve the Africans from their toothaches, and I freed my patients from this plague. The missionary is priest, teacher and physician in one person."[98]

The region to the south of Mahenge was not an area where mission medical services took pre-eminence over government services, however. On the contrary, during colonial times, it was the Government who invested much more in this area, because it came to be the focus of resettlement and development work in the 1940s. The mission in Ruaha did support some of this work, but not the medical arm of it.

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[94] TNA 461/27/1: Tanganyika Territory District Officer Ulanga et al., *Mahenge Division -Ulanga District Annual Report 1942*. For a similar account also TNA 461/27/1: Tanganyika Territory District Officer Ulanga et al., *Mahenge Division - Ulanga District Annual Report 1943*.

[95] TNA 461/27/1: Tanganyika Territory District Officer Ulanga, *Annual Report. Mahenge Division of Ulanga District. 1940*.

[96] PADSM 204/Ruaha 1: Kunibert Lussy, *Die Neugründung am Ruaha*. He gives the exact date and also a location name: "Mbulu Hill". PADSM 20/Mahenge Diocese 20 History: Callistus Mdai, *Diocese of Mahenge: Sketchy Notes on the History of the Diocese*. If P. Guido had the idea of starting the mission station, it was really P. Kunibert Lussy who would enter the Mission's history as the one that deserved the title of "real founder" of the new mission station. H., *Die Ernte ist gross. 25 Jahre Ruaha*, in Missionsbote der Schweizer Kapuziner in Afrika, 1953. Lussy was transferred to Ruaha from Ifakara in 1928 to support the Superior of Sali. Lussy also wrote a book: „Mit Kino und Kugel in Afrika" [more or less translating as With Film Camera and Bullets in Africa, not yet consulted by the author] And so he is remembered as a diligent photographer and a fine hunter. humem et al., *Interview mit Br. Edwin von Moos*, (2009).

[97] On the history of Muslim life in this area see Felicitas Becker, *Becoming Muslim*, 2008. On the history of this area Lorne Larson, *The Ngindo*, 2010.

[98] PADSM 204/Ruaha 1: Kunibert Lussy, *Die Neugründung am Ruaha*.

When the hospital orderly, Thomas Chirwa, had identified cases of Sleeping Sickness in the plains to the South of Mahenge, Maclean perceived a risk of new "focus of infection" being formed and he suggested the concentration of the people in Ulanga at the same time (and into a single concentration) as the one planned for Liwale. The rest was a matter of administration. Where the concentration should be was to result not from medical but from administrative considerations, as well as agricultural and population surveys.[99] In early 1940s, staff from the District Office visited the area in order to move 3,000 people to an area by the Luhombero River. The Mission in Ruaha was informed that the District Office found the proposed area was the "the most fertile of the whole district". A week later the Mission won support from the District Office to execute a correction of the river Ruaha, in order to end the flooding of the "most fertile" land and thus engaged in the reorganization of the ecological environment. The missionaries had for a long time felt that the artificial flooding practiced by the African farmers was responsible for the river inadvertently changing course. The missionaries held that flooding damaged plantations as well as roads.[100] With a large input of work, the Mission achieved the building of a dam and a canal from the river. At the end, the Mission was told by A.T. Culwick that, with the creation of the Ruaha canal, they had "saved the whole country".[101] The Mission also assisted the administration with the complicated surveys which were necessary to prepare the resettlement.[102]

Surveys were also carried out in order to establish the state of health and disease in the area. In 1941 Culwick reported that he was:

> "now in the middle of an investigation into the reasons for the deterioration of public health in the south of this division. It appeared to me essential to the well-being of this concentration to discover as soon as possible why the inhabitants of the Luhombero Valley were of such poor physique, so that measures could be taken to prevent the immigrants from following suit and descending to the low level of health which characterizes the present inhabitants of the Valley. The problem is, I need scarcely say, a complex one, as the study of any vicious circle is always apt to be."[103]

When the results were known, Culwick pushed plans for "a large hospital to treat blacks who are unbelievably miserable in terms of health. Out of 100 Blacks that were examined in the Luhombero region, 97 were sick and only 3 were healthy."[104]

Again, we see the same vicious circle blocking progress which we had encountered in the discussion on Culwick's scientific reports on nutrition and population. From that debate, Culwick also took the arguments that allowed him to lobby for an investment in good quality medical

[99] TNA 61/129H: *A report on Sleeping Sickness in the Ulanga District. [probably by G. Maclean]*.
[100] PADSM 204/Ruaha 1: *Quartalbericht Ruaha 1940 [1. quarter of the year]*.
[101] PADSM 204/Ruaha 1: *Quartalbericht Ruaha, April - Juni 1944*. On 26.09.1941 the Mission reported that the „Ruaha correction is accomplished. It took 60 men a day to work for 15 days to finish the canal with length of 1800m and a breadth of 3 m". PADSM 204/Ruaha 1: *Quartalbericht Ruaha, July-September 1941*.
[102] TNA 461/8/4: Robert Ollendorf, *Letter to A.T. Culwick, DO Mahenge. Ruaha 27.11.1941*.
[103] TNA 61/231G: A. T. Culwick, *Letter D.O. Mahenge to P.C.E.P. Luhombero 26.08.1941*.
[104] PADSM 204/Ruaha 1: *Quartalbericht Ruaha, July-September 1941*. This report also tells us quite detailed how the government planned to resettle the people.

services. Although the results of the survey were not yet available, Culwick claimed that "this concentration cannot ultimately succeed unless mass treatment for helminthic diseases is carried on for some time to come by an enlightened medical staff, and unless appropriate sanitary measures are rigorously enforced. It will be quite fatal to leave medical matters in the hands of tribal dressers; nothing less than a keen and able native dispenser, as Morton [Kumwenda] is, will do."[105] These medical services were no simple administrative façade, but measured in 'real' medical results.

## The dynamics of development: amelioration of dispensary medicine and new health issues

As we have seen in the preceding chapter, the "Ruaha hospital" in Chirombola with Morton Kumwenda at its head really became – alongside the hospital in Mahenge - the main training institution of government rural health services in the 1940s. Basic dispensary services were established in Chirombola by 1939.[106] With the Sleeping Sickness concentration, Chirombola had the best trained medical professional in the district, apart from Mahenge where there were two medical officers[107] After the Gabathulers left Mahenge in early 1946, Hospital Assistant Morton Kumwenda, was, for a short while, probably the best trained health worker delivering curative services within the Government system, in the Ulanga District.[108] Chirombola hospital treated large numbers of patients and was popular.[109] The hospital still exists today. Some of the interviewees remembered these early medical services, although the connection to Sleeping Sickness concentration was not made. Notably, when medical services were connected to epidemic disease, it seems to have been to meningitis rather than Sleeping Sickness.[110]

The documents in the archive show how health care measures had become mutually reinforcing. Once the concentration rolled, it seemed imperative to take care of the social problems it had created. Since people had been "accustomed to European medicine" (thanks to the presence of dispensaries), because of and thanks to concentration, dispensaries could serve the larger population better – but the standards of their services also had to be raised to make concentration viable both politically and from the perspective of health.[111] Health had been the

[105] TNA 61/231G: A. T. Culwick, *Letter D.O. Mahenge to P.C.E.P. Luhombero 26.08.1941*.
[106] TNA 61/129H: George Maclean, *Notes on Ulanga District [recieved 18.01.1940]*. "The dispensary dresser Cosmas, is stated to have studied up to Standard V." Furthermore, he was reported to have had four months of training in Mahenge hospital recently.
[107] The married doctor couple Gabathuler arrived in Tanganyika in 1938 and worked for the RC Mission until the early 1940s when, after a disagreement, the Mahenge hospital, including the doctors, was handed back to Government. For details see chapter 6. TNA 461 16/8: *"Tribal Dispensaries"*.
[108] Ca 1949 the German female doctor Adelheid Schuster, who had been employed to work in Kipatimu was employed by the Diocese to work in Kwiro/Mahenge.
[109] TNA 461 16/8 Vol I: A. T. Culwick, *Letter to Sleeping Sickness Officer, Tabora. 01.05.1943*.
[110] Interviews in Ruaha area, 2010.
[111] Culwick argued only half of the double bind TNA 461/27/1: Tanganyika Territory District Officer Ulanga et al., *Annual Report. Mahenge Division of Ulanga District. 1941*.

argument with which concentration had been pushed; now it had to be pursued in order to be true to the modernization project. Not only were improved health conditions a promise made to the Africans, it was also a promise that had been made towards the keepers of the empire themselves – healthy Africans became the condition for the legitimate government in the eyes of the administrator at least as much as in African eyes. This unlocked central government funds and boosted the dispensary medical system.

In the early years, Culwick sold the Ruaha and Luhombero concentrations as a success. Not only had he "concentrated a far larger population in the Ruaha Valley with the greatest ease", and "some 20'000 people have been freed from the threat of trypanosomiasis".[112] To Culwick, the result of the hospital in Chirombola was "great". It had treated more than 1,000 patients with curative medical treatment. Culwick saw rapid improvement in many patients, and pushed sanitation measures. He made people build pit latrines (the "problem of making them use them" was, however, not tackled yet, as Culwick had to report). But the Native Authorities were now convinced and had supported him well, according to his reports.[113] In 1943 he could "confidently say, without fear of contradiction that the people [...] find themselves more healthy, more prosperous and better fed than ever before in their history [...] And, what is so important, the rule of brute force which was necessary last year to keep them from starving or dying of disease, has given way to cooperation on the grand scale."[114] A year later, he was sure that "Sleeping Sickness is now to all intents and proposes a disease of no account in South Mahenge."[115]

This image of success hardly reflects the true state of public sentiment and public health. Let us look at outcomes a bit more closely. The "rule of brute force" of the resettlement was certainly still remembered. In 1941 the Pogoro Council, most probably headed by Culwick, had announced orders to whole groups of the population to move within four months and threatened those who resisted with a fine not exceeding Shs 50/- or to imprisonment for a term not exceeding one month or to both fine and imprisonment."[116] Resistance was considerable, and many people fled the sphere of influence of Chiefs and of district officials in particular. Culwick felt it was necessary to break resistance in a quick and harsh way – and he was supported and pressured by those chiefs who lost control over their subjects and taxpayers. This

[112] TNA 461/27/1: Tanganyika Territory District Officer Ulanga et al., *Mahenge Division -Ulanga District Annual Report 1942*. Additional areas of re-settlements in the Kilombero valley were then taken on by the administration. TNA 461/10/14: *file: Kiberege Concentration General*.
[113] TNA 61/104/H/1: A. T. Culwick, *Letter DO Mahenge to PC E.P. Mahenge 24.11.1941*.
[114] TNA 461/27/1: Tanganyika Territory District Officer Ulanga et al., *Mahenge Division -Ulanga District Annual Report 1942*.
[115] TNA 461/27/1: Tanganyika Territory District Officer Ulanga et al., *Mahenge Division -Ulanga District Annual Report 1943*.
[116] TNA 461/27/1: *Ulanga District - Mahenge Division. Orders made under section 8 Native Authority Ordinance by the Pogoro Council.*

lead to some disgruntlement with the Liwale Council, who disliked that Mahenge tried to reach over into their territories to get hold of the "deserters".[117]

The Chiefs on the other hand remained under much pressure to adapt to the 'modern' age. Many were now reported as "thinking along fruitful lines" for the development of the district. Efficiency rather than 'blue blood' was now wanted.[118] Sultan George Mbinji of Ruaha, who had been heavily dragged into the entire re-settlement affair, but seems to have become both unpopular with some of his people, and inefficient in the eyes of colonial government, was deposed in 1943 (much to the delight of the Mission who had feared that Mbinji pushed Muslim politics).[119] But people in the settlement continued to resist government and Mission modernization policies. The missionaries expressed frustration with the people who could not be convinced to plant foodstuff to add to their diet of maize and rice.[120] The mission also failed to convince Africans to assist in cleaning the canal in order to prevent and clear clogging.[121] The colonial administration kept the pressure on Chiefs high. In May 1947 they installed a 'foreigner' Mikael (Mohamadi) Mlolere in Chirombola, in order to make sure that the concentration was sustained.[122] But by that time, the scheme had started to collapse. The soils were exhausted. At the end of the 1940s, several Chiefs were allowed to return to their old homes.[123] All in all, however, to the newly arriving missionary, Ruaha at the end of the 1940s looked like a rich place, an impression he also gathered from his visitors.[124]

Sleeping Sickness had been controlled within a short spell of time, but Government continued to push its "vigorous" measures.[125] However, it was diseases other than Sleeping Sickness which posed real problems now. A Government Medical Officer reported that Culwick's statistics were showing "a dying race". "The general disease picture," the report says, "is one of increasing chronic infection of amount surpassing that found elsewhere." High numbers of leprosy cases, high infestation rates with hookworm, roundworm and filiaria and a notable shistosoma rate, all associated with widespread intense anaemia, were witnessed. Elders

[117] There is comparably much documentation on the people moving and the activities in policing their movement in 1941 and 1942 in TNA: 61/104/H/1.
[118] TNA 461/27/1: Tanganyika Territory District Commissioner Mahenge, *Annual Report Ulanga District 1944 [09.01.1946]*.
[119] PADSM 204/Ruaha 1: *Quartalbericht Ruaha, July-September 1943*. The mission also took offence by Mbinji's support to a witchraft cleansing movement, see further down.
[120] PADSM 204/Ruaha 1: *Quartalbericht Ruaha, Januar-Februar-März 1946*.
[121] PADSM 204/Ruaha 1: *Quartalbericht der R.C.M. Ruaha, Okt. - Nov.- Dez 1946*.
[122] PADSM 204/Ruaha 1: *Chronik der Missionsstation Ruaha, April-Juni*.
[123] TNA 461/27/1: Tanganyika Territory District Commissioner Mahenge, *Annual Report Ulanga District 1949 [31.12.1949]*. This re-re-settlement seems to have received approval from the government: H., *Die Ernte ist gross. 25 Jahre Ruaha*, in Missionsbote der Schweizer Kapuziner in Afrika, 1953. The schemes in Liwale area had ended in a fiasco in 1947 already. Thaddeus Raymond Sunseri, *Wieding the Ax*, 2009, p. 114.
[124] "visitors remark how people here are well dressed, throughout." PADSM 204/Ruaha 1: P. Aristides *Ruaha Vierteljahresbericht. 01.07.1948-01.10.1948 [06.10.1948]*. Aristides reported similarly at the beginning of 1948 when he said that Ruaha was able to sell much maize for the hungry population of Ifakara. PADSM 204/Ruaha 1: P. Aristides *Ruaha Quartalsbericht. 31.03.1949*.
[125] *Die Schweizer Kapuziner in Afrika. Jahresbericht 1943*, 1943, p. 19; TNA 461/27/1: Tanganyika Territory District Officer Ulanga et al., *Mahenge Division -Ulanga District Annual Report 1943*.

complained to the Medical Officer that migratory labour brought in a higher number of infections, especially hydroceles.[126] Notably, Cerebrospinal Meningitis (CSM) was almost epidemic in the early 1940s.[127] In the beginning, CSM was considered as a disease that spread to the settled population through migrant labour. The measure against CSM thus was stronger control in the (new) labour camps.[128] But in September 1941, CSM was everywhere in the district and it returned around that time of the year in the following years, with 112 notified deaths in August and September 1942 alone.[129] Culwick's view on the epidemic shows how much his administrative politics could distort his scientific and hard-edged perspective. At a time when understanding ecology became a prime accomplishment of science, it seems that Culwick's reasoning was too monocausal. Notwithstanding Culwick's invocation of science, in practice he seems to have been guided by his belief in the panacea of administrative modernization.[130] According to Culwick, the problem in fighting CSM, again, was the scattered population.[131] Bringing people to live in closer settlements would allow for the establishment of medical services which could fight CSM successfully, as Culwick claimed one year into the epidemic, as long as Government money was spent on it.[132]

However, the political ecology of the disease speaks for CSM as a disease that is connected to the sleeping sickness settlements, too. A Senior Medical Officer indeed understood CSM in the Ruaha valley as a result of the resettlements.[133] The missionary sources testify to the virulent character that CSM took in this area. By a decree of Bishop E. Maranta, schools had been interrupted from 15 November 1941 up to, in some places, 30 August 1943 due to *Genickstarre*, quite certainly meaning CSM.[134] Measles epidemics also ravaged the Mission before the Chirombola clinic started to help with vaccinations.[135] "Anyhow, mortality this year is more than double compared to earlier and normal times," reported the missionaries who had been in Ruaha since the late 1920s.[136] CSM put the resettlement at risk, but also made the resettled people dependent on the medical services offered by the Culwick government. The disease

[126] The doctor felt that the problem was less virulent in Ulanga than on the coast. This fact would rather support the explanation forwarded by the elders. TNA 450/439: W.A. Young, *Report of S.M.O. to Ulanga District 10.08.1942-22.08.1942 [28.08.1942]*.
[127] Culwick wrote: 'endemic'. TNA 461/27/1: Tanganyika Territory District Officer Ulanga et al., *Mahenge Division -Ulanga District Annual Report 1943*.
[128] TNA 61/231/2: Wilson, *Letter to Dir. of Med. Services. Kilosa, nn.11.1937*.
[129] TNA 461/27/1: Tanganyika Territory District Commissioner Ulanga et al., *Kiberege Division -Ulanga District Annual Report 1941*; TNA 461/27/1: Tanganyika Territory District Commissioner Ulanga et al., *Kiberege Division -Ulanga District Annual Report 1942 [01.01.1943]*.
[130] Lukas Meier, *Swiss Science*, 2014, 52-57.
[131] TNA 461/27/1: Tanganyika Territory District Officer Ulanga et al., *Annual Report. Mahenge Division of Ulanga District. 1941*.
[132] TNA 450/439: A. T. Culwick, *Letter to Senior Medical Officer, Morogoro. District Office Mahenge 11.11.1942*. TNA 61/231G: A. T. Culwick, *Telegram to PC. E.P. 13.08.1943 Medical Matters Mahenge*.
[133] TNA 450/439: W.A. Young, *Report of S.M.O. to Ulanga District 10.08.1942-22.08.1942 [28.08.1942]*.
[134] PADSM 204/Ruaha 1: *Quartalbericht Ruaha, Oktober- Dezember 1941*; PADSM 204/Ruaha 1: *Quartalbericht Ruaha, July-September 1943*.
[135] PADSM 204/Ruaha 1: *Quartalbericht Ruaha, Juli, August, September 1945*; PADSM 204/Ruaha 1: *Quartalbericht Ruaha, April-Juni 1943*.
[136] PADSM 204/Ruaha 1: *Quartalbericht Ruaha, April-Juni 1943*.

became, in Culwick's eyes endemic. But he also believed at one point – an explicit example of the belief in (bad) science - that CSM had something to do with ultraviolet radiation, and was a function of climate.[137] In 1972 missionary sources still reported a CSM epidemic in Ruaha.[138]

Unlike Culwick with his scientific beliefs, Africans did make a connection between colonialism, the severing of social ties and the appearance of new diseases.[139] Therefore Africans invested in practices of social healing. Witchcraft and witchcraft cleansing raged at that time in Ulanga and particularly in the concentrated settlements.[140] These events have found considerable attention in historical research that has shown that these anti-witchcraft activities were meant to heal the wounds the colonial resettlements had inflicted on the social body.[141] In 1943 Bishop Maranta complained that Chief Mbinji of Ruaha had called a famous magician into the district.[142] Ngope also treated the mission people, in an operation that was quasi-compulsory for all adults in the Ruaha area. The missionaries estimated that about 95 per cent of the Christians participated in these exorcisms.[143] But the colonial administration did not see anything anti-social in the activities of this greatly respected witch doctor who came into the Ruaha area from the Kiberege division of Ulanga.[144] Culwick showed even less understanding than the Bishop. He wrote:

> "We are dealing here with a conflict between two rival bodies wishing to abolish black magic by supernatural means, and as far as a Government servant I do not feel it right for me to favour the methods of one at the expense of the other. Nor would I be acting fairly in the eyes of the natives if I prohibited their magico-religious practices and did not take similar action regarding certain Mission rites. I note that the Mission 'absolutely forbids any kind of magic practices', to quote Bishop Edgar, but what is religion and faith to one is a magic and superstition to another, a situation raising questions of value on which it is undesirable that Government should pronounce."[145]

The Mission also lost in another way. The resettlement also meant that the Mission had to rearrange its plans in the area. Some of the Mission stations that had been planned never materialized and Sali, the proud station in the hills, was isolated from the population – after an extended struggle the Mission was only allowed to keep about 50 households in Sali: workers

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[137] TNA 461/27/1: Tanganyika Territory District Officer Ulanga et al., *Mahenge Division -Ulanga District Annual Report 1943*.
[138] Institutsarchiv Baldegg B III 7,1: Sr. M. Theodosina, *Letter to Sr. M. Jacinta. Ruaha 11.06.1972*.
[139] In 1937 for example there was much talk about 'ugonjwa wa kapatula', the short trousers disease in Ifakara, although the term originally designated the influenza epidemic in 1918. See Gregory Maddox, *Disease and Environment*, 2010, p. 208; James Giblin, *Precolonial Politics*, 1996, pp. 143-145. PADSM 153/3: *Quartalbericht von Ifakara. Ostern 1937*.
[140] There were reports about rise in witchcraft activities in 1938 which might have been unrelated to Sleeping Sickness concentrations, although the source of the medicines was located in Liwale, which was then already planned for concentration TNA 461/28/9: R.H.R. Hayne, *Monthly Report for August 1938. Mahenge Division - Ulanga District (12.09.1938)*.
[141] Lorne Larson, *Problems in the study of witchcraft eradiction movements in Southern Tanzania*, in Ufahamu, 1976; DAK & PA Dreier Lorne Larson, *Witchcraft eradiction [manuscript]*; Maia Green, *Witchraft Suppression Practices*, in Comparative Studies in Society and History, 1997; Peter Pels, *Politics of Presence*, 1999, pp.245, 262; Mkeli Pio Senga Mbosa, *Colonial production and underdevelopment in Ulanga district, 1894-1950* 1989, pp. 154-158.
[142] TNA 61/128 vol II: Edgar Maranta, *Letter to PC E.P. DSM nd [arrived 09.03.1943]*.
[143] PADSM 204/Ruaha 1: *Quartalbericht Ruaha, Januar-März 1943*.
[144] TNA 61/128 vol I: *file "witchcraft"*, folio 192, dated 1939.
[145] TNA 61/128 vol II: A. T. Culwick, *Letter to P.C.E.P.. DSM. Mahenge, 22.03.1943*.

and their families who were considered necessary for the economic enterprise run by the Mission.[146]

## Building the Developmentalist State: Culwick's Benign Autocracy

In the early 1940s, Culwick's hitherto positive feelings about Ulanga sank to rock-bottom. In his reports about the district, Culwick painted a grim image of the deteriorating situation:

> "We have to deal with a phenomenon for which British policy makes no allowances, a population which has to a large degree lost the instinct of self-preservation [...] they are in their present appalling state of health and so heavily infested with parasites of all descriptions."[147]

Drastic changes were needed. The 'big experiment' launched development on a new scale but still with many unknown variables, and an elusive destination:

> "what the ultimate moral pattern of Bantu society will look like we cannot say, but one thing is certain, the African's new world is and will be hybrid, drawing on the ideas and forms of both western civilization and primitive tribal society and pleasing the orthodox of neither."[148]

All the more, to Culwick, the Empire seemed like a vessel within which Africans could develop in a socially healthy way under the stern guidance of the European administrator and scientist. But he also made the criticism that administrative actions lacked an in-depth knowledge and scientific understanding of African society.[149] He now called for a large investment, using terminology that later became a motto of independent Tanzania under Julius Nyerere: "such a plan, a concerted advance against ill health, ignorance and poverty all along the front, will cost millions. That is the capital necessary to ensure a steady dividend of health, wisdom, prosperity and efficiency..."[150]

It is interesting to see how Culwick's views echoed in an article in the Tanganyika Notes and Records by one of the foundational figures of the African Association. Petro Mntambo took up Culwick's argument about hybridity, or rather about the African as being between two worlds, which hindered progress. Based on Culwick, Mntambo argued that what was needed was:

> "not [to] destroy what you have found in Africa and replace it with your own, you would give the African no footing ground. What you have met in Africa is a sacred heritage handed down from father to son as the years pass by. Better still construct your new sciences on the African foundations."[151]

Like Mntambo, Culwick felt that scientists in Africa would bring technocratic and unfounded knowledge, which was of little value to the African. "The uninformed nature of public

[146] TNA 461/8/4: P. Philemon *Letter Superior Mission Sali to DO Mahenge. Sali 17.08.1942*.
[147] TNA 461/27/1: Tanganyika Territory District Officer Ulanga et al., *Annual Report. Mahenge Division of Ulanga District. 1941*.
[148] A. T. Culwick, *Good out of Africa. A study in the Relativity of Morals*, 1943, p. 34.
[149] A. T. Culwick, *Good out of Africa. A study in the Relativity of Morals*, 1943.
[150] A. T. Culwick, *New Beginning*, in Tanganyika Notes and Records, 1943, p. 5.
[151] Petro Ch. Mntambo, *The African and how to promote his Welfare*, in Tanganyika Notes and Records, 1944.

opinion," Culwick concluded, "is a crime for which we [sic!] scientists are primarily responsible."[152]

But Culwick was far from being pro-national independence. Rather he defended a system of "benign autocracy". Within this system of governance, science was a science that was firmly to remain within the boundaries of an authoritarian system. In scientifically planned societies, "individual liberty is restricted for the general good". Culwick concluded that:

> "the doctrine of the liberty of the subject as applied in Tanganyika is incompatible with the scientific control and exploitation of the environment for the African's good."[153]

Science and modern planning was to rule the communitarian Native, to guide him into 'community development': here was the governance mode of rural development. In his words, the authoritarian side of the Tanzania developmentalist state cast its shade already.[154] But the nationalists would eventually make sure that colonial authoritarians like Culwick no longer played an active role in the new state.

As a figure, A.T. Culwick is thus a symbol of a change in the style of state and government in rural Africa in the 1930s and 1940s. His work in the 1930s shows him and his wife as early propagators of science and fieldwork in Ulanga. This placed him in the midst of struggles about the re-configuration of legitimate expertise in rural Africa.[155] Culwick's career is also symbolic for the end of the administrative officer as a ruler over development. The years of his greatest power were the early 1940s when a jack-of-all-trades with a university background could still be at the helm of rural development discourse. These years built on his practical, slightly non-conformist science approach, but when development failed to deliver in Ulanga his arguments and plans quickly lost pertinence and he was denigrated to the status of an amateur.[156] The wide range of sciences had become too complex for a single-handed District Commissioner. At the same time, the application of science failed to produce the straightforward effects it had promised. It meant that institutions were needed to recalculate science, like research councils and labs. Culwick's career even featured this: in the later 1940s Culwick teamed-up in with well-known British specialists on Sleeping Sickness, like John Ford and H. Fairbairn and went from the field into the lab.[157] On the other hand, the new problems produced by expert interventions necessitated new techniques of government: more of the development panacea, pushed, in Culwick's view, in a 'benign authoritarian' style.

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[152] A. T. Culwick, *Good out of Africa. A study in the Relativity of Morals*, 1943, p. 42.
[153] A. T. Culwick, *New Beginning*, in Tanganyika Notes and Records, 1943, pp. 2, 5.
[154] "Community development" was an invention of the 1940s and 1950s, see Michael Jennings, *Building Better People*, in Journal of Eastern African Studies, 2009, pp. 97-100. An early argument about the role of missionaries in community development in Walbert Bühlmann, *Afrika*, 1963, p. 300.
[155] Peter Pels, *Global Experts and African Minds*, in Journal of the Royal Anthropological Institute, 2011.
[156] Lukas Meier, *Striving for Excellence*, 2012, p. 51: quote from Culwick's successor Conan-Davies.
[157] Culwick's re-incarnation as a laboratory specialist for the trypanosomes cannot be explained here. It is important to note however, that he did not write on the administration of sleeping-sickness control, but on basic laboratory research partly based on chemical hypotheses developed by Culwick, e.g. in: H. Fairbairn et al., *The transmission of the polymorphic trypanosomes*, in Acta Tropica, 1950; H. Fairbairn et al., *A new approach to trypanosomiasis*, in Annals of tropical medicine and parasitology, 1946; John Ford et al., *The trypanosomiasis problem*, in East African Agricultural Journal, 1948.

## Health and the rural

Health was a field where such new techniques could be deployed – in the form of biopolitics. The 1930s are indeed a transitional phase from a rather territorial to new pastoral forms of legitimization of the local state. Taddeus Sunseri has argued that sleeping sickness in Southern Tanganyika was still only an excuse to move people into closer settlement.[158] Similarly, Lukas Meier argues that science's role in the sleeping sickness campaigns was to mitigate the effects of policies already implemented. He concludes that only after the major resettlements were established in about 1945, and the problems they suffered from became virulent that the models of science and development came together.[159] I think, however, that the road to better science was paved by the 'amateurish' science of A.T. Culwick and in particular by his belief in development, in the feasibility of a big 'experiment' if guided by scientists. The resettlements in Ulanga in the early 1940s were addressing new issues, issues which were born from the application of welfarist governance to rural Africa and from its marriage with science.[160] It was under the influence of his scientifically grounded view of a district in decline and in need of development to break a vicious cycle, that A.T. Culwick made use of the diagnosis of Sleeping Sickness to realize the model villages the administration had been dreaming of since the beginning of the Mandate. It was Culwick's belief in science which made him engage medicine and biopolitics in the administration not only as a (token) state institution, but in order to enable the state to act in a developmentalist way – and apply force on the social body in order to change social behaviour. Health became a fundamental category of development practice. The great moral story of healing coupled with medical services and institutions as new consumables promised and legitimized development to both colonizer and colonized. As interventionism expanded it seized on ordinary life in rural environments in novel ways. A sort of 'humanitarian' Biopower that had shaped interventions aimed at the body of the industrial worker increasingly focused on the rural African.[161] Delivering social services in a rural environment was a challenge to the state though, as we have seen in the preceding chapter.

In order to govern the rural, knowledge about social traditions and social change was important. But just as important was knowledge about diseases and soil conditions – fertility of the human population and of the floor became crucial fields of science in the colony. As the sciences were transported into the rural new objects of knowledge were created, amongst them a new cultural perspective on medicine. Since the 1920s, medical men in East Africa had developed a discourse of medicine in Africa that incorporated the African body, culture and

[158] Thaddeus Raymond Sunseri, *Wieding the Ax*, 2009, pp. 97-101, 107.
[159] Lukas Meier, *Striving for Excellence*, 2012, pp. 43-48.
[160] William Beinart et al., *Environment and Empire*, 2009, p. 197; Kirk Arden Hoppe, *Lords of the Fly*, 2003, p. 110.
[161] Thomas W. Laqueur, *Bodies, Details, and the Humanitarian Narrative*, 1989; Michel Foucault, *Naissance de la biopolitique*, 1994; Sebastian Conrad, *Eingeborenenpolitik*, 2004. Inspiring in its theoretical approach, though his arguments apply to the 'post-high-modernism' era: Richard Rottenburg, *Social and public experiments*, in Postcolonial Studies, 2009. See also: Nikolas Rose, *The Politics of Life Itself*, 2006; Giorgio Agamben, *Homo Sacer*, 1997.

diseases and which made them turn to rural medicine in specific ways.[162] Tropical medicine took on a 'rural native' dimension with anthropologists contributing to the study of medical cultures, and psychologists starting to develop theories about the African psyche.[163]

Unlike any other science, medicine accelerated the establishment of a two-faced interventionist and developmentalist state in rural Africa. The colonial state, or rather the Empire which Culwick served, has been characterized as full of „tensions between the exclusionary practices and universalizing claims of bourgeois culture".[164] Often enough, exploitation and philanthropy, brutal power and compassion were conjoined into a state with two faces and 'moods', as Nancy Hunt described it: the nervous and security-oriented state caused destruction at the same time as it tried to rekindle life.[165] Scientific reason was linked to both faces of the state and has shaped the 'state' with its moods and its paternalism by a "critical capacity" inherent to science.[166] Out of these tensions, a new form of colonialism was created - an "era of interventionist colonialism" as Helen Tilley termed it.[167] In the name of soil conservation, irrigation and improved agricultural production, villagization campaigns were undertaken across Africa, but they rarely brought better services for the population.[168] Medical development brought new *dawa*, new health posts, and offered at least a bit of a new safety net. How much this depended on 'development' became clear, when it was planned to stop the Sleeping Sickness dispensary services in Ulanga in 1947, but then it was paid for in the name of 'development'.[169] Culwick was eventually given the chance to devise an Ulanga Rural Development Scheme in 1945, a scheme which included the continuation of the dispensary as sleeping sickness control measure under government funding. Heavily challenged from the outset, the scheme was a failure and stopped in 1951.[170]

The power of knowledge termed scientific and produced in the field become reinforced with state power and was subsequently used as knowledge that carried interventionist colonialism deeply into rural society often under the heading of 'community development'.[171] However, the success of interventions was very limited. Culwick had witnessed the limitations of

[162] Osaak A. Olumwullah, *Dis-ease in the Colonial State*, 2002, pp. 205-216; Warwick Anderson, *Cultivation of Whiteness*, 2003, in particular chapter 5.
[163] S. Mahone, *Psychiatry in East African Colonies*, in International Review of Psychiatry, 2006.
[164] Jane Burbank et al., *Empires in World History*, 2010, pp. 8-14. Anna Laura Stoler et al., *Tensions of Empire*, 1997, p. 37.
[165] Nancy Rose Hunt, *Suturing new medical histories* (Basel, 2011). See also Paolo Palladino et al., *Science and Imperialism*, in Isis, 1993, pp. 97-98; John Farley, *Bilharzia: A History*, 1991, pp. 3-4.
[166] Helen Tilley, *Africa as Living Laboratory*, 2011, p. 23. William Beinart et al., *Experts and Expertise*, in Afr Aff (Lond), 2009.
[167] Helen Tilley, *Africa as Living Laboratory*, 2011, pp. 3, 11-12.
[168] Steven Feierman, *Peasant Intellectuals*, 1990; Christophe Bonneuil, *Development as Experiment*, in Osiris, 2000, pp. 261-264. Starting in the early 1930: the Gezira scheme in the British Sudan; the "Office du Niger" or the 'centralization' in Southern Rhodesia. For the latter see: Malcolm Hailey, *An African survey a study of problems arising in Africa south of the Sahara*, 1957, p. 766; T. O. Ranger, *Peasant Consciousness*, 1985, pp. 86-88. See also William Beinart, *The rise of conservation in South Africa: settlers, livestock, and the environment 1770-1950*, 2003, pp. 357. Similar measures were then enforced as 'betterment schemes' in South Africa. C. J. De Wet, *Moving Together, Drifting Apart*, 1995.
[169] TNA 461/27/1: Tanganyika Territory District Commissioner Mahenge et al., *Annual Report Ulanga District 1947*.
[170] Lukas Meier, *Swiss Science*, 2014, pp. 52-57.
[171] Michael Jennings, *Building Better People*, in Journal of Eastern African Studies, 2009.

science as well.[172] The bodies of 'rational' knowledge did not produce a clean and well-ordered world.[173] On the contrary, they opened new channels of communication through which different perspectives were articulated, and they complicated structures of authority in the local state. Nor did scientific expertise bring swift progress to Ulanga. When science legitimized the large-scale reorganization of settlement patterns, it exposed Africans to threats to agricultural production and to their health. Africans were exposed to these risks when they were brought under experimental schemes and exposed to bad science, while their own knowledge was ignored by the internal politics of science projects.[174]

## Epilogue

Culwick's era, the era of the jack-of-all-trades, came to an end in the mid 1940s. When he designed the Ulanga Rural Development Scheme, Culwick had come under fire for being an amateur. Culwick's subsequent career was very unsavory. After a spell as a politician in Kenya during the Mau Mau period, Culwick turned into a frustrated imperialist supporting and working for Apartheid in South Africa. Culwick bragged on the back cover of his book that British publishers had refused to print his pamphlets, *Britannia waives the Rules* and *Back to the Trees,* and so they were eventually produced in South Africa, and *Britannia* was even translated into German by an avowedly Nazi publishing house.[175] His criticism of African nationalists who had wiped out the 'benign autocracy' was, however, not as exceptional as one would wish, and it seems that there was quite a large number of copies printed. Now, Chief Towegale was named by Culwick as his witness for the argument that the African did not wish to have democracy.[176] Culwick's version of developmentalism depended on authority – science and expertise pushed modernization, but it had not even attempted to work towards democracy.

[172] A. T. Culwick, *Good out of Africa. A study in the Relativity of Morals*, 1943.
[173] Foucauldian (or Gramscian readings) of the colonial world have argued the power of knowledge (or knowledge as embodied in culture) to order the colonial world. Alexander Butchart, *Anatomy of Power*, 1998; Dagmar Engels et al., eds., *Contesting Colonial Hegemony*, 1994. For a discussion of this see the section on birthing practices. It seems unlikely that live in the 1930s or 1940s looked 'ordered' from the perspective of an ordinary African in Ulanga.
[174] Helen Tilley, *Africa as Living Laboratory*, 2011, p. 138ff; Henrietta L. Moore et al., *Cutting Down Trees*, 1994. Diana Wylie, *Starving on a Full Stomach*, 2001, p. 15. Joseph Morgan Hodge, *Triumph of the Expert*, 2007, p. 54.
[175] A. T. Culwick, *Afrika den Afrikanern? Englands Verzicht auf Weltherrschaft*, 1966; A. T. Culwick, *Back to the trees*, 1965; A. T. Culwick, *Britannia waives the rules*, 1963.
[176] A. T. Culwick, *Britannia waives the rules*, 1963, pp. 13, 16, 53.


"Sr. Arnolda with mothers who delivered in her clinic"[1]

Sr. Arnolda with mothers and children of Ifakara, n.d.[2]

[1] *Die Schweizer Kapuziner in Afrika. Jahresbericht 1937/38*, 1938, p. 14.
[2] PSKO: Untitled large Album with series of photographs of Ifakara.


"Hospital Midwife Theres (Mamma Clara)." Inside St. Francis Hospital, 1959.
Dr. Rolf Diethelm, who made this photo available to me
remembers that this was probably shot
while she was on her way to bury a placenta
close to Sr. Arnolda's rose garden
on the hospital grounds.

# Chapter 5 Maternity Care, Knowledge, Welfare and Morals

Sister Arnolda's midwifery practice in the St. Anna maternity unit at Ifakara Mission takes centre stage in the present chapter, which links the local practice of medicine with imperial and global discourse. The Capuchin Mission and the Baldegg sisters were very proud of this pioneering enterprise which emerged as a model institution and established a field of activity at Mission dispensaries that was to gain enormous symbolic and practical importance in Mission health care in Ulanga.[1] The maternity unit was an intervention that aimed to 'transform mothering', a process that was based on the fact that "being pregnant, giving birth and nurturing" is not only a biological state but also a "coagulation of power [...] experienced by mothers".[2] Missions played a fundamental role in the provision of medicalised assistance during pregnancy and for child care in Africa and Sr. Arnolda was the agent of a most intimate modernizing intervention into local society.[3] Many women in Africa have "eagerly" taken up the changes proposed by missions, or have transformed them into new styles and identities.[4] The history of the St. Anna clinic in Ifakara helps us to understand how modernity was linked to a broader negotiation of gender relations and family through issues of health and fertility and how this eventually constituted a central field of development practice.

Human reproduction and was a central issue in African society.[5] Fertility, birthing and the rearing of healthy children were always critical, and African families produced a huge body of procedures and knowledge about the management of fertility. A rich complex of moral discourse and economic interests were acted out in rituals that established kinship and

[1] Schwester Erika Lischer, *50 Jahre Baldeggerschwestern in Tansania 1921-1971 (manuscript)*, (PADSM/Institut Baldegg, 1971). Almost all mission dispensaries would later offered midwifery services and a maternity with lying-in facilities: see chapter 10.
[2] Margaret Jolly, *Colonial and Postcolonial Plots*, 1998, pp. 1-2.
[3] Nancy Rose Hunt, *Bébé en Brousse*, 1997 [1988], p. 308. Jennifer Beinart, *Darkly Through a Lens*, 1992. Nancy Rose Hunt, *Colonial Lexicon*, 1999. The topic of maternal and child health care services and the cooperation of Government and Mission services is nicely laid out for Tanzania: Walter Bruchhausen, *Practising Hygiene*, in Dynamis, 2003; Michael Jennings, *Matter of Vital Importance*, 2006.
[4] Megan Vaughan, *Curing Their Ills*, 1991, pp. 23, 66-70.
[5] Iliffe follows this topic across his John Iliffe, *Geschichte Afrikas*, 1997. Lynn Thomas, *Politics of the Womb*, 2003.

belonging, and the Culwicks asserted somewhat boldly that "no child is unwanted".[6] There remains an interesting tension between the social perception of women's health and fertility as endangered, including the proliferation of medicines to treat the health of women, on the one hand, and the marginalization of young women, for example in times of food shortages, on the other.[7] James Giblin has shown how family economies, gender relations and migrant labour put women into a position of strain and domesticity in first half of the 20th century. This was not the result of a unified patriarchal strategy. The lack of access to material resources for women was characteristic in a situation where care and reproductive elements of the family and clan economy were exposed to strain because of the disruptive character of migrant labour and colonial rule in general.[8] It was a time rife with generational conflict around issues of gender.[9] From the 1920s, African reproductive politics were increasingly colliding and combining with imperial politics as pushed by colonialists and missionaries, producing an entanglement that linked the intimate to the global in a debate that included almost everyone, because almost everyone believed that the regulation of reproductive behavior was of great importance.[10] It was the moment indeed when the "time of the maternity" had come.[11]

In 1949, in the midst of colonial government debates about development, knowledge and the role of education in Ulanga, the Baldegg Sister Arnolda (Berta) Kury, also known as "Sista/Mama Noda" in the local nomenclature, wrote about her accomplishments in maternal and child health care in the 20 years that had passed since her arrival in Ifakara:

> "Concerning childrearing there has been much headway in Ifakara and its environs. Although at the beginning the people had been so recalcitrant, now they are very responsive to pleas and suggestions. The initial opposition was understandable. The old midwives lost their income due to our interventions [...]. The native woman will always call the same midwife if she is available. Another reason for the discontentment was the awareness that old traditions were being lost. None of the women that patronize the [Mission] maternity asks about old custom. Proudly, they say they give birth the European way, not according to heathen custom. Formerly, very many children had to die due to faulty nutrition. Today one does not find a single mother in the neighborhood that shoves porridge into her newborn on the first day. Before, hardly was the child born, a thick porridge from maize was prepared and the tiny mouth stuffed with it. Whenever the child was crying, crumbs dropped into the

[6] Family and fertility were staple themes in ethnographies. For a condensed version of missionary ethnography on these issues in Ulanga, compiled under missionary headings see: Sidonius Schoenaker, *Hintergründe*, 1965, especially part III "Geburt" and IV "Marriage". A rich description of ritual practice of the Wabena in Culwick and A. T. Culwick et al., *Ubena of the Rivers*, 1935, chapter XVI. These studies raised the issue of slavery to the point of acknowledging that a great grandfather of Bishop Mchonde had many slaves, but are mute on the repercussion of slavery into their contemporary society. Sidonius Schoenaker, *Hintergründe*, 1965, p12-13. Jan-Georg Deutsch, *Emancipation withouth Abolition*, 2006; Eric Allina, *Slavery* (paper presented at the African History Research Seminar, University of Basel, 2012). A. T. Culwick et al., *Ubena of the Rivers*, 1935, p. 369.

[7] A. T. Culwick, *Study of Factors*, in East African Medical Journal, 1938/1939, p. 6; Stacey Langwick, *Bodies, Politics and African Healing*, 2011, p. 90.

[8] James Giblin, *Divided Patriarchs*, 2000., pp. 178, 181-194, 195 Thaddeus Raymond Sunseri, *Vilimani*, 2002, pp. 178-184.

[9] Nancy Rose Hunt et al., eds., *Gendered colonialisms in African history*, 1997. Kathleen R. Smythe, *Fipa Families*, 2006; James L. Giblin, *History of the Excluded*, 2005.

[10] Lynn Thomas, *Politics of the Womb*, 2003, pp. 4, 173-177; Steven Feierman, *Healing as Social Criticism*, in African Studies, 1995.

[11] Nancy Rose Hunt, *Colonial Lexicon*, 1999, chapter 5 and 6, the quote by a female interviewee on p. 266. Nancy Rose Hunt, *Bébé en Brousse*, 1997 [1988].

> throat. Now, child mortality declined substantively. Proudly the mothers say, they feed according to the ways of the modern (new) times."[12]

This is one of the few instances in which one of the Swiss Catholic nuns in Tanzania writes an account of her work. Her statement is set within a major field of health concerns that still has occupied a central field within gender-related development discourse since the colonial era. In the Belgian Congo, Sr. Arnolda's work would have fitted perfectly in the colonial state's program for Maternal and Child health.[13] Apart from stating the connection to a larger imperial context, Sr. Arnoldas report relates the main coordinates within which the work of the Swiss Catholic women took place, and tells it as a story of the reform of habits and knowledge – a story of progress and survival in Africa. This chapter talks about this very 'progress' but describes it more as a programme and process rather than a result, and tries to detail some of the complexities in historical situation in Ulanga to which the progressive programme contributed.[14]

## Making Mothers

Birth was a critical moment in the life of the family and intervention in this moment meant that the depth of interference was problematic and put everyone on a slippery terrain, involving "careful negotiation between the cultures of the colonizer and the colonized".[15] Interventions into fertility management cut into the social fabric of society and they were much more challenging to local societies than the cutting edge of the surgeon's knife.[16] Mother and child welfare services touched on the history of social reproduction rather than disease, and were more about the apparatus of civilization than about the repair of a broken part of the body. As such, they engaged a large repertoire of social techniques that organized fertility, maternity and childhood, social networks of kin and allegiance to the practice of medicine.

Missionaries and colonial government propelled the domestication of African women from the end of 19th century, and they did so particularly in the period under discussion here.[17] Even pre- and post-independence national politics would assign domestic and motherly roles to women, as African historians Nakanyike Musisi and Hibba Abugideiri have shown.[18] Control was crucial to domestication, but the 'moral mission' behind the reconfiguration of African gender relations was coded differently. In rural Africa "making mothers"[19] was infused with images of motherhood that were particularly powerful within Christian imagery. In Catholic Christianity

[12] PADSM Box 153 Ifakara Mission and Parish 4: Sr. Arnolda M. Kury, *Maternity Ifakara*.
[13] Nancy Rose Hunt, *Bébé en Brousse*, 1997 [1988], see especially pp. 292-293.
[14] Jean Comaroff et al., *Modernity and its Malcontents*, 1993, p. xii.
[15] Heather Bell, *Frontiers of Medicine*, 1999, p. 228.
[16] John L. Comaroff et al., *Revelation and Revolution II*, 1997, pp. 323-364. Also Tabitha Kanogo, *Medicalization of Maternity*, 2001.
[17] Barbara Reeves-Ellington, *Women, Protestant Missions*, in Social Sciences and Missions, 2011. T. O. Beidelman, *Altruism and Domesticity*, 1999. Megan Vaughan, *Curing Their Ills*, 1991, pp. 23, 66-71. See also the edited volume: Karen Tranberg Hansen, *African encounters with domesticity*, 1992. John L. Comaroff et al., *Ethnography and the Historical Imagination*, 1992, pp. 266ff.
[18] Nakanyike B. Musisi, *Politics of Perception*, 2002, p. 99-109. Hibba Abugideiri, *Gender*, 2010.
[19] Jean Marie Allman, *Making Mothers*, 1994.

the rise of Marian cults in the mid 19th century and again in early 20th century was an attempt to assign specific 'motherly' roles on women in an urbanizing world. As a figure and role model, Mary personified the four ladylike virtues of piety, purity, submissiveness and domesticity and, compared to Eve, she was better placed to bear the message that one must not fall for the sins of modernity.[20]

Missions generally felt that by 'making mothers' they were liberating women from the oppression of polygamous marriage, indiscriminate divorce, and exploitative agricultural labour.[21] This discourse of liberation was in part at least, probably a vestige from the time of the emancipation from slavery.[22] "For a woman," Pater Jesuald wrote in 1936, "polygamy equals slavery."[23] But the Mission also tried to 'protect women' from their husbands' pressure to seek medical services from local 'charlatans'.[24] This missionary discourse about the liberation of women shows that it took a new direction which linked freedom to knowledge and education and to scientific motherhood.

The trend to hear the voice of science in the process of modernization of rural Africa interacts strongly with the global re-configuration of motherhood in the early 20th century. The scientification of motherhood was pushed by institutions and individual mothers alike.[25] In general, the early 20th century was "a time of expansion in maternal and child welfare services" and of social gynaecology. Maternities were pushed and carried by different actors in different parts of the world. Across the globe, this type of institution gained ground in the 1930s.[26] The promoters of maternal and child health were often private initiatives and organizations.[27]

Missionaries and the state brought domesticity and the scientification of motherhood together under the umbrella of maternalism. Maternalism has become a key term to a branch of (historical) research that looks at the gendered aspects of welfare.[28] The term itself is strongly

[20] Mirjam Moser, *Frauen im katholischen Milieu*, 2004, pp. 50-52. Dana L. Robert, *American Women in Mission*, 1998, pp. 366-367. Pius XI: Encyclica casti connubii of 1930 that addresses issues of the role of marriage and motherhood in the light of family planning and eugenics: James J. Keneally, *Eve, Mary, and the Historians. American Catholicism and Women*, 1980. In Ulanga the figure of Mary became important especially as that of a mother who has lost her child. Maia Green, *Priest, Witches and Power*, 2003, pp. 71, 118-119.

[21] Andreas Eckl, *Grundzüge einer feministischen Missionsgeschichtsschreibung*, 2009, pp. 134-135; Ulrike Sill, *Encounters*, 2010, pp.35-46; Jean Marie Allman, *Making Mothers*, 1994; Deborah Gaitskell, *Getting Close to the Hearths of Mothers*, 1992.

[22] Patrick Minder, *Suisse Coloniale*, 2011, pp. 258-262; Michael Weidert, *Solche Männer*, 2007, pp. 143-145.

[23] P. Jesuald Loretz, *Fastenbilder aus Tabora*, in Missionsbote der Schweizer Kapuziner in Afrika, 1936, p. 44. See also: Peter Pels, *Politics of Presence*, 1999, p. 159.

[24] TNA 61/128 vol I: *file "witchcraft"*, folio 31.

[25] Rima Dombrow Apple, *Perfect Motherhood*, 2006, e.g. p. 10; Irvine Loudon, *Childbirth*, 1993.

[26] Ulrike Lindner, *Transfer of European Social Policy*, in Journal of Global History, 2014. Lara Marks, *Metropolitan Maternity*, 1996, p. 290. For Germany: 2274 Ilana Löwy, *The Social History of Medicine: Beyond the Local*, in Soc Hist Med, 2007, p. 469. Motherhood remained a contested terrain of knowledge: Angela Davis, *Motherhood in Oxfordshire*, 2008.

[27] Anne Emanuelle Birn, *Child Health in Latin America*, in História, Ciências, Saúde-Manguinhos, 2007; Anne Emanuelle Birn, *Skirting the Issue*, in American Journal of Public Health, 1999. Hygiene movements centered on mothers and schools in Switzerland too: 4711 Augustine Widmer, *Hüterin der Gesundheit*, 1991.) In this framework, women were carriers of processes of professionalization: Verena Naegele et al., *Himmelblau und Rosarot*, 2004. Alfred Fritschi, *Schwesterntum*, 2006 [1990].

[28] Marian van der Klein et al., *Maternalism Reconsidered*, 2012. Sonya Michel et al., *Introduction: "Mother Worlds"*, 1993; Susan Pedersen, *Family, Dependence, and the Origins of the Welfare State*, 1995 [1993]. Rebecca Jo Plant et al., *Introduction: A new generation of scholars on Maternalism*, 2012, p. 4; Donna J. Guy, *Women Build the Welfare State*, 2009;

rooted in the history of the early 20th century, when it was coined to denote politics in support of birthing and of positive eugenics.[29] Around the globe, efforts were made to "make more women reproduce and to make them better mothers".[30] These efforts were tied in with the provision of welfare institutions. Under the gendered regime of maternalism this meant that colonial welfare policies addressed males as workers and women as mothers. At the base of practical welfare activities lay a widespread concern about the dwindling health and welfare of populations. Walter Bruchhausen has outlined that debates about fertility, abortion, and malpractices in child care and especially in feeding babies have been a colonial and missionary topic in East Africa from the last decade of the 19th century.[31]

Historians differ about the role they assign to the missions in the history of maternity under colonialism.[32] At the end of the 1920s the Rockefeller Foundation, whose work in many parts of the globe – but not in Ulanga – was the starting point for rural health, initiated a programme of health posts In Latin America that concentrated particularly on the health of children and mothers.[33] Maternal and children's health organizations by that time had become national and transnational welfare players who legitimized their sphere of activity in an imperial context and who organized rights and benefits in corporative policies. The Belgian Congo was arguably the leading African territory where ideas about 'delivering children under hygienic conditions', 'weaning surveillance' and the "art" of caring for babies more generally were being cast into colonial health care.[34] In Tanganyika, the Government acted rather slowly on matters of training for curative services for maternal and child health, also because it felt that maternities were less attractive than welfare clinics.[35] "Medical missionaries," Megan Vaughan wrote in

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Anne Emanuelle Birn, *Skirting the Issue*, in American Journal of Public Health, 1999. Lisa D. Brush, *Love, Toil, and Trouble*, in Signs, 1996. Anne Emanuelle Birn, *Child Health in Latin America*, in História, Ciências, Saúde-Manguinhos, 2007.

[29] Omnia Shakra, *Schooled mothers*, 1998, 133-134. Anna Davin, *Imperialism and Motherhood*, in History Workshop, 1978, fn 77.

[30] Carol Summers, *Intimate Colonialism*, in Signs, 1991, p. 788.

[31] Juhani Koponen, *Population: a dependent variable*, 1996, pp. 28-29; Walter Bruchhausen, *Practising Hygiene*, in Dynamis, 2003, pp. 91-94. Fertility and demographics are "of the most studied aspect of African women's lifes" Stacie Ann Colwell, *Vision and Revision*, 2001. Anne Hugon, *L'historiographie de la maternité en Afrique subsaharienne*, in Clio. Histoire, femmes et sociétés, 2005.

[32] Forbes sees missions as central, Manderson the state: Geraldine Forbes, *Health and hegemony*, 1994; Lenore Manderson, *Sickness and the State*, 1996; Margaret Jolly, *Colonial and Postcolonial Plots*, 1998. See also: Margaret Jolly, *Colonial and Postcolonial Plots*, 1998, pp. 7-8.

[33] Michael Worboys, *Colonial Medicine*, 2003; Anne Emanuelle Birn, *Skirting the Issue*, in American Journal of Public Health, 1999; Eric Andrew Stein, *Vital Times*, 2006. In contrast to Birn, the theme of women and children support does not get much attention in John Farley, *To Cast Out Disease*, 2003. Lindner reads the situation very differently: Ulrike Lindner, *Transfer of European Social Policy*, in Journal of Global History, 2014, p. 222.

[34] Nancy Rose Hunt, *Bébé en Brousse*, 1997 [1988]. Nancy Rose Hunt, *Colonial Lexicon*, 1999, pp. 196-236. For a view on East Africa: Lynn Thomas, *Politics of the Womb*, 2003, p. 55. Also Deanne van Tol, *Mothers, Babies and the Colonial State*, in Spontaneous Generations, 2007; Deborah Gaitskell, *Getting Close to the Hearths of Mothers*, 1992; Hibba Abugideiri, *Scientisation*, in Gender & History, 2004. Anne Hugon, *L'historiographie de la maternité en Afrique subsaharienne*, in Clio. Histoire, femmes et sociétés, 2005; Anne Hugon, ed. *Histoire des femmes en situation coloniale: Afrique et Asie, XXe siècle*, 2004.

[35] Walter Bruchhausen, *Practising Hygiene*, in Dynamis, 2003, p. 110. Kenya was even slower according to: Lynn Thomas, *Politics of the Womb*, 2003, p. 55.

1991, "made maternal and child health their 'baby', whilst governments quite systematically neglected it."[36]

This alleged neglect was not that straightforward, however. In the case of Tanganyika, the government started a limited program of subsidies to missions for maternal care services. Even when mother and child health care was the "sphere of the voluntary agency" and government politics were cautious about the value of investment in mother and child health care services, it was the Government who pushed missions into action and mission agencies received growing subsidies from the Government for this type of work.[37] From about 1926, the first rural maternity clinics in Tanganyika were run by a female medical doctor, Maynard, who was married to a missionary.[38] Oswald Masebo offers a differentiated perspective on these welfare activities. In the welfare clinics, he has argued, the colonial discourse focused mainly on women's "ignorance".[39] This blame resulted from the anti-traditional discourse that was part of a process of scientification of motherhood. As a reproach it was largely unwarranted, as the quote from Arnolda shows with all the examples of modernizing mothers. Masebo has shown how women were mainly interested in good quality (medical) care, and this made them prefer mission to Government welfare centres.[40] Because of their preference for Mission rather than Government welfare services dedicated to public health concerns, African women made the missions into the prime provider and source for biomedically informed mother and child health care.

## Imperial Knowledge

In Ulanga the Capuchin Mission was a major propagator of the modernization of motherhood. The Swiss missiologist, Johannes Beckmann, claimed mission sisters in particular had been engaged in a large-scale enterprise for the rescue of women and children.[41] He described that a conference on the assistance to African children had put the topic on the Catholic agenda in 1931, when the Catholic missions were still divided about the regulation of midwifery practices executed by female members of congregations. In 1933 an apostolic Delegate announced in a letter to the heads of mission societies in (East) Africa that a commission was investigating the question of midwifery, and that in the meantime it should be practiced by sisters in those areas where there were no doctors. In 1936 the Propaganda Fide

[36] Megan Vaughan, *Curing Their Ills*, 1991, p. 23.
[37] Michael Jennings, *Healing of Bodies, Salvation of Souls*, in Journal of Religion in Africa, 2008, pp. 47-50. Michael Jennings, *Matter of Vital Importance*, 2006, pp. 228, 236.
[38] Michael Jennings, *Matter of Vital Importance*, 2006, pp. 237-240.
[39] Oswald Masebo, *Society, State and Infant Welfare*, 2010, pp. 100-101.
[40] Oswald Masebo, *Society, State and Infant Welfare*, 2010, pp. 189-190.
[41] Johannes Beckmann, *missionsärztliche Fürsorge in den katholischen Missionen*, 1943, p. 13. The director of nursing training in Baldegg wrote a teaching book on child nursing, testifying to the importance of the issue to the Baldegg Sisters, who also ran homes for children in Switerland: Sr. M. Angelina Hodel, *Kinderpflege*, 1914; 1921 ff.

instructed the missions to create specific congregations for midwifery services.[42] Did the requirements from the Catholic Mission field change the politics of the Catholic Church in medical matters? We might almost come to that conclusion, seeing how in Ifakara birth assistance had already begun in the early 1930s.

The Bishop was the centre of the Mission authority. However, a mission nurse was not engaged in a Church network only. In the early 1930s, colonial officials had sought to interact more intensely with the mission medical services in Ifakara. District officials considered the Mission as having a role to contribute to progress in Ifakara, and pushed the Chiefs to bring forward girls for training in midwifery in the Mission dispensary as early as 1932.[43] Mission sisters and Mission nurses were engaged in alternative networks of knowledge. The Baldegg sisters trained in medical schools and hospitals that were run by their own communities. Sisters also communicated within their congregations, in small intimate circles. Baldegg sisters thus had a network of their own between the establishments in Switzerland and Tanganyika, and exchanged news in letters which were even published in their own newsletter-style journal *Providentia*. Baldegg sisters also communicated within the mission field because mission stations were always nodes of communication where missionaries met in person or communicated through the mission staff that travelled between the stations. The chronicles in the mission stations named the visitors, and sometimes even mentioned bits of news they brought.

There were forces that pressed these networks to codify knowledge more formally. Towards the end of the 1920s the Mission had to adapt to colonial state demands to send better trained staff to Tanganyika.[44] What was needed was specialized knowledge which was relevant in the colony, both because it was codified in the right terms and useful in the colonial situation.[45] It is not surprising, then, that a middle space developed in which missionary and colonial interest were entangled and where the Mission and the colonial administration cooperated very closely, not least because the Mission could ill afford to be absent at the time of Sr. Arnolda's arrival in Ifakara, when the idea of training African women as midwives had spread all over the continent.[46] In Uganda, missionaries (CMS) and Government cooperated from 1918 in the running of a Maternity Training school "train teenage girls from all over Uganda and send them to care for women and their babies."[47] In Sudan, the midwifery training which had been

[42] Sacra congregatio de propaganda fide, *Instructio pro religiosis mulierum institutis, ad tuendam puerorum matrumque vitam in locis missionum: constans ac sedula (11.02.1936)*, in Acta Apostolicae Sedis, 1936; Johannes Beckmann, *Die katholische Kirche im neuen Afrika*, 1947, 130-131. For a voice from German mission medical circles pushing midwifery practices see Thomas Ohm, *ärztliche Fürsorge*, 1935.
[43] PAL 1057.J. Ifakara / Briefe: H. Schildknecht: Hieronymus Schildknecht, *Letter to E. Maranta Ifakara 06.04.1932*.
[44] Marita Haller-Dirr, *Bischof Gabriel Zelger*, in Helvetia Franciscana, 1995, p. 102.
[45] For an introduction to the medical professionalization in Africa see: Murray Last, *Professionalisation of African Medicine*, 1986.
[46] For Tanganyika: Walter Bruchhausen, *Practising Hygiene*, in Dynamis, 2003, 107-109; Denise Roth Allen, *Managing Motherhood*, 2002, chapter 2.
[47] Carol Summers, *Intimate Colonialism*, in Signs, 1991, p. 799.

propagated since 1921 "sought to create a class of modern, trained Sudanese midwives, out of, and in rivalry to, an entrenched class of traditional midwives known as dayas." Bell also argues that the low status of the occupation of midwifery was common to British and Sudanese societies.[48] Although the Sudanese programme was state run, it was energized by female actors.

Such programmes, although built on the training of 'native women' established not a traditional but a new category of health workers, who were propelling the colonial project at the same time as they reformulated it.[49] In 1932, the chiefs in Ulanga were asked by the District Officer to send girls to the Missions where they could be trained in midwifery.[50] In Ifakara, two "state trained" midwifes, called Lidwina und Emilie, worked with Sr. Arnolda. Together they also trained local girls in midwifery, which were then posted to other Mission stations, or even the Government Dispensary in Kiberege. Lidwina and Emilie and the other assistants must have taught Sr. Arnolda a lot. They were trained in midwifery and managed the limited resources with more ease than Sr. Arnolda. The knowledge they must have shared with Arnolda on local medical and social practices was the basis on which Arnold built her in-depth understanding of local society.[51]

## Giving Birth the 'European Way' at the St. Anna Maternity in Ifakara

Giving birth "in the bush", as the missionaries called it, was a difficult and perilous affair. During labour the life of both the pregnant mother and the unborn baby were in danger. Missionaries up to the 1970s were denouncing traditional birth practices in Ulanga as agonizing to the mother. Birthing was a very social moment with many members of the lineage involved (but only females present). But it could also be physically a solitary and socially critical moment in case parturition did not progress smoothly. The woman in labour might be blamed and her moral conduct during pregnancy questioned, while birth assistance could take rather harsh forms.[52] The most revealing 'inside' account we posses is that of Louise Jilek-Aal who toured the Ulanga bush in the late 1950s as a travelling doctor both independently and with the Catholic Mission, and described vividly how assisting birth in the bush to her was like walking a tight-rope. Her example is an emotional account of her assistance to a 15 year old girl who gave birth

[48] Heather Bell, *Frontiers of Medicine*, 1999, pp. 198-228., basically the same as: Heather Bell, *Midwifery Training*, in The Journal of African History, 1998. This was also true for Indian midwifery: Supriya Guha, *From Dais to Doctors*, 1998. David Arnold, *Health and Hegemony*, 1994, pp. 163-168. French West Africa was different: here obstetrics was "controlled by postmenopausal women who" in this case "derived considerable prestige and material rewards from their activities." Jane Turritin, *Colonial Midwives and Modernizing Childbirth in French West Africa*, 2002, p. 73.

[49] Jane Turritin, *Colonial Midwives and Modernizing Childbirth in French West Africa*, 2002, p. 83. For a later period in Tanzania see Stacey Langwick, *Bodies, Politics and African Healing*, 2011, pp. 121-129.

[50] PAL 1057.J. Ifakara / Briefe: H. Schildknecht: Hieronymus Schildknecht, *Letter to E. Maranta Ifakara 06.04.1932*.

[51] Pater Klemens Hug, *St. Annaheim Ifakara*, in Missionsbote der Schweizer Kapuziner in Afrika, 1938.

[52] Adelina Laube, *Gebräuche und Eigenheiten der Negermädchen und Frauen*, in Missionsärztliche Caritas, 1945, pp. 43-44; Rudolf Geigy et al., *Mädchen-Initiationen*, in Acta Tropica, 1951, pp. 315-319. Louise Jilek-Aall, *Call Mama Doctor*, 1979, pp. 101-112. Sidonius Schoenaker, *Hintergründe*, 1965, pp. 50-55, this resumes a number of missionary ethnographical contributions.

to twins in her village home, halfway between two remote Mission stations which did not yet have maternity units at that time (Ruaha and Sali). Tension gradually built up when the delivery did not progress well. First the girl in labour was rebuked for her moral conduct as a *'mwali'* (a young girl who had begun menstruation), then the elder midwives assisted her rather violently and beat the girl with allegations that she was "lazy". Then these women were sent away by Jilek-Aal who was soon herself reproached by the girl for giving her medicine that was not doing any good. At this stage, the father of the delivering woman also hit her so that she might confess the name of the adulterer who caused the blockage of the birth. The first baby was stillborn. When Jilek-Aal took the baby to the nearby river to wash it and try to reanimate it, this was seen as an abduction of the body by the doctor for some dangerous magic medical practice. Finally, there was relief and joy when the second twin, a girl, was born alive and healthy.[53]

Sister Arnolda assisted birthing in the 'bush' too, i.e. at the homestead of the family of the baby, although there was little trust in her capabilities at first. When she was exposed to the "cruelty" of the African women who traditionally assisted birth, Arnolda was motivated to "help the black mothers".[54] Arnolda thus tried to get the women to come to her maternity unit for their labours. At the beginning, she had been brought infants whose mothers had died during labour. We do not know how often this happened, but it is certainly an astonishing event, that also testifies to the status missionary welfare had gained as a fostering institution for children and a possible patron.[55]

> "I explained to the people, that we do not want to save the babies only, but the mothers, too. [...] when I was called to assist the mother was often already dying with terrible pain, high fever and I immediately saw the lack of basic hygiene. Some I could help, but not all. When I failed I used the opportunity to explain to those present – often 60-80 people – and to the men in particular, why it had happened this way."[56]

Arnolda and the Mission built a maternity unit which put the image of African birth practices into stark contrast: "Now the expecting mothers had a protective roof over their head and they received devoted and loving care instead of the beatings. And when the mother has given birth, she can stay with the baby, and does not need to lie on the hard ground and eat for a full week from unwashed pots and plates."[57]

[53] Louise Jilek-Aall, *Call Mama Doctor*, 1979, pp. 101-112.
[54] PADSM Box 153 Ifakara Mission and Parish 4: Sr. Arnolda M. Kury, *Maternity Ifakara*.
[55] I have not established the background to these events. One would expect that there was some kind of politics of alliance and clientship involved. An individual example is provided by Adelina Laube, *Gebräuche und Eigenheiten der Negermädchen und Frauen*, in Missionsärztliche Caritas, 1945, p. 45.
[56] PADSM Box 153 Ifakara Mission and Parish 4: Sr. Arnolda M. Kury, *Maternity Ifakara*.
[57] Pater Klemens Hug, *St. Annaheim Ifakara*, in Missionsbote der Schweizer Kapuziner in Afrika, 1938.

## Sr. Arnolda, Figure

Although almost all accounts recorded by Sr. Arnolda seem to have been lost, she is one of the most important and prominent historical figures of Swiss Mission history in Tanzania.[58] Her life and work has acquired somewhat mythic proportions. Her story is somewhat reminiscent of a hagiography that tells of how she sacrificed her life for the people of Ifakara.[59] Born in 1902 as Bertha Kury in Reinach close to Basel, Sr. Arnolda had come to Ifakara as a young woman of about 26 years, and in the course of her life became a powerful personality, reportedly the first women to ride a bicycle in Ifakara, and to receive a funeral "equaling that of a chief" when she died of diabetes in 1963.[60] At that time – a moment when nationalist expectations were realized all over Tanganyika, the death of Sr. Arnolda was, according to the missionary reports, mourned as the 'mother of the people of Ulanga'.[61] "I don't have anything to report about myself, I work all day", she wrote in 1957, but she also self-assuredly stated that "without exception [the mothers] are all grateful to me for my services."[62]

The maternity work of Sr. Arnolda certainly lent itself to be used in missionary propaganda both in Ulanga and in Switzerland. The number of assisted births was repeatedly presented by the Mission. Flags were hoisted when, on the occasion of the 4000th birth about two decades after she had opened the St. Anna Maternity clinic, Sr. Arnolda moved her maternity unit into the new hospital at Ifakara.[63] The missionary intellectual and church administrator, Edelwald Steiner, highlighted the fundamental role of Arnolda in creating Bishop Maranta's desire to invest in Ifakara. Maranta's decision was based on his trust in Arnolda's standing in Ifakara and her knowledge of the people.[64] The narrative of Arnolda's centrality for medical development in Ifakara is unquestioned to this day and Mama Noda is remembered, at least by the older people, as a founder of the large Mission and Designated District Hospital in Ifakara.[65]

[58] Sr. Marie-Ruth Ziegler, *Weisse Mama von 5000 Kindern*, in Ite, 1997. PADSM 156/10: Sr. M. Jacinta Dähler, *SFH 75 years jubilee... Why do you think that St. Francis was famous?*
[59] PADSM 153/5: Hieronymus Schildknecht, *Sr. M. Arnolda Kury [ca 03.09.1962]*; Sr. Marie-Ruth Ziegler, *Im Rückspiegel*, in Baldegger Journal, 2005. P. Hilmar Pfenniger, *Zum Titelbild; Sr. Arnolda Kury [obituary]*, in Missionsbote der Schweizer Kapuziner in Afrika, 1963.
[60] Sylvia Sr. M. Buess, *Schweizer Missionare: Schwester M. Arnolda Kury, 1902-1962, Baldegg*, in Sendbote, 1991. Sr. M. Berchmans, *Aus den Missionen*, in Providentia, 1945; Schwester Erika Lischer, *50 Jahre Baldeggerschwestern in Tansania 1921-1971 (manuscript)*, (PADSM/Institut Baldegg, 1971), notes on Ifakara by Sr. Maria Paula on pp. 54-58.
[61] PADSM 153/5: Hieronymus Schildknecht, *Ifakara 1962/63*; Walbert Bühlmann, *Afrika*, 1963.
[62] PAL 1057.J.Briefe: Schwestern v. Baldegg; Einheimische Schwestern; Privater: Schwester M. Arnolda, *Letter to E. Maranta, Ifakara 12.05.1957*; PADSM Box 153 Ifakara Mission and Parish 4: Sr. Arnolda M. Kury, *Maternity Ifakara*.
[63] Maria Schwester Marty, *Tumempata, tumempata*, in Missionsbote der Schweizer Kapuziner in Afrika, 1959.
[64] I discussed this issue with P. Edelwald Steiner in Luzern on 02.12.2010. P. Edelwald Steiner, *Das Porträt des Erzbischofs*, in ite, 1969.
[65] Interviews and Focus Group Discussions in Ifakara 2009 and 2010. Other sisters are also warmly remembered in the places where they worked and are identified with medical institutions, e.g. in Ruaha and Mofu.

## Sr. Arnolda, Midwife

Bertha Kury completed the full two-year training course as a Nurse in Baldegg in 1923 and 1924.[66] After the completion of her religious training, she came out to Ifakara in October 1928 as Sr. Arnolda. In 1931 she ran a drug dispensary with a large lobby, and also opened a kind of a 'clinic'. It was also at this time that Sr. Arnolda assisted the first birth. This "so-called hospital" was, according to Hieronymus Schildknecht, more like a "nursing home for the sick and the elderly". In its three rooms, Sr. Arnolda could receive her patients and she could also provide 'native style beds' for more than two dozen in-patients in separate male and female wards, with about 33 beds in 1935.[67] In the third room, Sr. Arnolda started her maternity practice. She saw 'her' medical facility as a "refuge for local women".[68] About nine months later, she claims, she had already assisted 86 maternity cases with good results. The women would stay for about ten days, before they were transferred into local style houses.[69] In 1937, on the feast of St. Anne,, adjacent to the hospital a new building was put into use as a maternity unit.[70] The maternity building was, in Mission words "not quite a European clinic, but certainly a symbol of the love of the Good Shepherd." Services to Christian women were for free, non-Christians had to pay "a small fee."[71]

In Ifakara, Arnolda became a skilled apothecary who herself mixed the medicine she used and, in the later years of her career, frankly addressed medical issues like Gonorrhea in her introductory lectures to doctors, who acknowledge her great medical knowledge.[72] Much, if not most, of Arnolda's knowledge was born from practice. In midwifery she was an autodidact, who would, at least at first, not allow doctors into the field of midwifery.[73] However, her practical knowledge was good and in the 1950s was registered by the state as a nurse/midwife.[74] She had been a midwifery teacher to her African co-workers Lidwina and Emilie, to Therese and to a number of women who were meant to practice in the villages. She was also the teacher to one of the first lay missionary nurses from Switzerland serving in Ifakara. Nina Disler, who was later to

[66] Institutsarchiv Baldegg B IV 11,6: *[file] Baldeggerschwestern welche die Pflegerinnenschule in Baldegg oder Sursee besuchten*.
[67] PADSM 153/5: Hieronymus Schildknecht, *Vorgeschichte zur Gründung der Mission Ifakara*. Sr. Bernadette Gabler, *Die Sorge um unsere kranken schwarzen Bürder und Schwestern im Apostol.Vikariat Daressalaam (Ostafrika)*, in Missionsärztliche Caritas, 1935.
[68] Sr. Arnolda M. Kury et al., *Frauenklinik St. Anna*, in Missionsbote der Schweizer Kapuziner in Afrika, 1947.
[69] TNA 61/129G folio 19: Claude Hollingworth Philips, *Ifakara R.C. Mission Hospital and Dispensary / Kiberge Government Dispensary / Chonde Labour Camp*.
[70] PAL 1057.J. Ifakara / Briefe: H. Schildknecht: Hieronymus Schildknecht, *Letter to E. Maranta. Ifakara 25.07.1937*.
[71] Pater Klemens Hug, *St. Annaheim Ifakara*, in Missionsbote der Schweizer Kapuziner in Afrika, 1938.
[72] PA Diethelm Rolf Diethelm, *Tagebuch*. *Interviews with Karl and Irmengard Schöpf, Zams 23-25.07. 2007*.
[73] PAL 1061.4: Adelheid Schuster, *Letter to E. Maranta. Mahenge 05.07.1943*. That Arnolda had a problem to accept the expertise of a medical doctor, as Schuster claimed, is not supported by how Carl Schöpf remembered working with Sr. Arnolda in St. Francis hospital from the mid 1950s. But he left the maternity entirely in the hands of Arnolda. PAL 1057.J.Briefe: Schwestern v. Baldegg; Einheimische Schwestern; Privater: Schwester M. Arnolda, *Letter to E. Maranta, Ifakara 12.05.1957*. Sr. Sara, *Chronik des St. Francis Mission Hospital Ifakara*. Interviews with Karl Schöpf, 23-25.7. 2007.
[74] TNA Acc.450/HE/178/16: Tanganyika Territory Director of Medical Services, *Letter 178/16/129 to Archbishop Maranta, DSM 08.04.1953*.

become a propagator of alternative female-headed midwifery in Switzerland, witnessed Sr. Arnolda's work in Ifakara:

> "There [in Ifakara] an old nun took care of the women. The latter had to lie down on a bench of Mahagoni, underneath which lay, transversally, a local black midwife, who was, most of the time, drunken and had to be nudged with a kick of the foot, when she was needed. That time, I consider my first midwifery era [...] from the old nun I learnt a lot by watching. She worked intuitively and she could not explain to me, what it was she did. She had no knowledge from the books whatsoever. Everything she had learnt by doing it herself."[75]

## Negotiating Midwifery Techniques

Sr. Arnolda spoke of the maternity unit as a sanctuary [in German: Zufluchtsort"], although hygiene played a large role. She would, however, not speak of the maternity unit as a biomedical institution. It was the beneficence of Christian *caritas* which provided the essence of the place in her eyes.[76] In the maternity unit, Arnolda could make felt her influence on the entire family and she worked to do so not only in a medical fashion but very much as a pastor.[77] However, when Arnolda went to see the Sultan, Hassani Njohole, and tried to convince him to intervene on her behalf in birthing practices, he rejected her suggestions (at least at first). Njohole stipulated that the way childbirth was being managed had been tested by tradition.[78] Arnolda persisted, visited homes, sat with the elders, and tried to convince the men about the new approach. Not least, Arnolda persuaded pregnant women and their husbands to come to her hospital for childbirth. She promised to look after the expectant mother well, and to give her food and care. Especially in times of want, this was a substantial offer. "Still, there was always a big row between the husband and his in-laws," Arnolda remembered; "People meddled in the discussion from all sides, some of them in agreement with the Mission, husband and wife, others telling her to go to hell."[79] A visitor from the Government side observed in 1939 that "all classes

[75] Franziska Löpfe, *Auf sich gestellt. Die Lebensgeschichte der Hebamme Nina Disler* (Norderstedt, 2007). p.61-71. Here: 64-65. Disler became one of the pioneers of the reform movement to de-medicalizing midwifery in Switzerland.
[76] Sr. Arnolda M. Kury et al., *Frauenklinik St. Anna*, in Missionsbote der Schweizer Kapuziner in Afrika, 1947, p. 95.
[77] PADSM 153/5: Hieronymus Schildknecht, *Vorgeschichte zur Gründung der Mission Ifakara*.
[78] Schildknecht noted that at least in the case of making Christian mothers attend the mission maternity, they received Sultan Hassani Njohole's support: PADSM 153/5: Hieronymus Schildknecht, *Vorgeschichte zur Gründung der Mission Ifakara*. It was Chief Hassani's politic to allow the mission to keep Christians within their sovereignty in similar matters, e.g. for male circumcision see PADSM 153/3: *Quartalbericht von Ifakara. September 1937*. Pater Hieronymus Schildknecht, *Sultan Hasani und die Mission Ifakara*, in Missionsbote der Schweizer Kapuziner in Afrika, 1952. There were other Chiefs in Tanganyika taking more active roles in the biomedicalization of women's health. In Uluguru, the area where Pels did his research on Catholic mission, not far from Ifakara, Chief Kingo, strived to receive specific assistance to female health services and wished to receive a female doctor into the district: "Why have we no lady doctor as they have in other districts? Many women when suffering from female diseases are treated by male doctors and in maternity cases it is very hard that they should have to put up with the indelicacy of being treated by a male doctor. [...] that many women when they are ill or in cases of pregnancy leave their villages for the purpose of being treated with native medicine, and many of them are only made worse and become really dangerously ill." TNA 61/297: M.G. Kingo, *Letter to DO Morogoro. Morogoro 01.09.1930*. TNA 61/297: *Letter DO Morogoro to Prov.Comm.E.P.. Morogoro 24.09.1930*. The matter died a quick death when the Medical Department made it understood that there was no money from central Government coffers available: TNA 61/297: *Letter DO Morogoro to Prov.Comm.E.P.. Morogoro 06.10.1930*.
[79] PADSM Box 153 Ifakara Mission and Parish 4: Sr. Arnolda M. Kury, *Maternity Ifakara*. An important element in such debates was the question of liability for the safeguarding of the mother's life (the local concept involved was called *ulishi*).Sr. Arnolda M. Kury et al., *Frauenklinik St. Anna*, in Missionsbote der Schweizer Kapuziner in Afrika, 1947, pp. 94-95.

of the population are admitted but as yet the pagan community have been few in number.[80] For Christians, the maternity service was free, non-Christians had to pay only a "small fee "of 2 shillings".[81]

In her maternity unit, Sr. Arnolda shared her knowledge about child nursing with the women who had borne children. Interest in witnessing Arnolda's work was great, and women were always checking out her work at the maternity and asking the pregnant women about her experience. Ten to fifteen women arrived to see how the birth went, and Arnolda had to accept their presence in order to establish confidence. According to Arnolda's account, there were many rumours afloat about the tools used in birthing, such as knives, tongs and scissors.[82]

According to herown reports, it took Sr. Arnolda at least six years to establish a substantial amount of trust among the women. At that stage she had succeeded, "after much soliciting" in reaching the point when "every Christian mother comes here to give birth. Once we had achieved this, we could start to reduce some of the services; especially we could reduce the size of the daily ration [of food]."[83] Arnolda's account shows that building trust was a gradual process, and it was perhaps less a matter of gaining trust through direct interaction with the white women from abroad and more the result of a sustained discussion and observation of the new birthing practices by the local community. Taking Arnolda's pragmatic approach to knowledge into account we can also assume that the medical techniques in the maternity unit underwent substantial changes in the course of time – changes which reflected the debate in the Ifakara community. Neither the change nor the debate can be reconstructed from the sources available for this dissertation. It was a matter of realigning knowledge about birthing and fertility, a political issue of allowing the white Mission sister access to an important field of kinship management and a philosophic debate about the world the community lived in. These new birthing practices were linked to the time, and the people in Ifakara had to come to an agreement about the place of traditional know-how about fertility. It was now possible, and by the 1950s even en vogue to give birth the European way, or rather in the fashion of the times. Behind this lay a shift in the way women themselves articulated their thoughts. The words used by the Catholic women as early as 1937 to thank the Bishop for the maternity services were: "*asante sana kwa nyumba yetu*", (Thank you very much for our house).[84]

For Sr. Arnolda, the St. Anna maternity unit was a tool with which she and the Mission worked to break the influence of 'heathen' authorities over the people in Ulanga. Negotiations in

[80] TNA 450/439: *Letter to Dir. of MS. The Medical Office, Kilosa 01.07.1939*.
[81] Pater Klemens Hug, *St. Annaheim Ifakara*, in Missionsbote der Schweizer Kapuziner in Afrika, 1938. PADSM 153/3: Hieronymus Schildknecht, *Quartalbericht von Ifakara. Ostern 1938*.
[82] PADSM Box 153 Ifakara Mission and Parish 4: Sr. Arnolda M. Kury, *Maternity Ifakara*. Note how well this description fits with the interest in medical procedures in Yakusu described by Hunt. On rumours and medical practice see Luise White, *Speaking With Vampires*, 2000.
[83] PADSM Box 153 Ifakara Mission and Parish 4: Sr. Arnolda M. Kury, *Maternity Ifakara*.
[84] PADSM 153/3: Hieronymus Schildknecht, *Jahresbericht 1938/39. Ifakara*. This quote is clearly a piece of missionary propaganda, too. The agency of the women existed, but in this case very much in the interest of the Mission, and the report does not reach very deep into the motivations of the women to claim the maternity as theirs.

which she offered attractive services, therefore, were one side of her strategy only. Letters and reports also betray how Sr. Arnolda constructed the bearers of 'tradition,' who claimed authority on issues of fertility, as her adversaries. One would expect that Sr. Arnolda was first of all posed against the enemy figure of many a missionary, the *Mbui*. This was usually an influential elder man within the kin group who was ultimately responsible for the wealth of the lineage and possessed the fertility medicine needed to make its members and the group of kin prosper. These medicines were used to sustain fertility throughout a women's child-bearing years.[85] At the beginning, the missionaries knew little about the social and religious role of the *Mbui*. 'Mbui' was a figure combining the role of 'witchdoctor' and personifying the power of the old customs.[86] The role of the *Mbui* was better understood in the late 1940s only after some of the missionaries did serious anthropological work and a developed a differentiated picture of the role of the *Mbui*, laying emphasis on his protective role in relation to social and spiritual relations.[87] With the Wapogoro more than other groups in Ulanga, the *Mbui* was explicitly a "shrine medium".[88] In general, he was a "secular as well as spiritual authority", a "doctor cum father" to the lineage".[89]

The *Wambui* never really seem to have bothered Arnolda very much in a negative sense. It was female figures, however, who headed Sr. Arnolda's list of adversaries by far:

> "Heathen old ladies who practised midwifery according to their fashion up to now [...] They lost one or two Swiss Francs [sic!] of income, and, furthermore, the chance to perform their heathen hocus-pocus at the moment of childbirth."[90]

These were the older women in whose hands the actual process of birthing lay. In Ulanga these older women, according to the Culwicks, were those women "particularly famed as midwives or as experts of initiation, but they usually combined this kind of work with a knowledge of some other branch of the profession [of a healer, witchdoctor etc]..."[91] These women were considered dangerous by Sr. Arnolda because their practices were so unscientific

[85] Maia Green, *Priest, Witches and Power*, 2003, pp. 96-97.
[86] "diviner" in: P. Ansgar Häne, *Im Geiste und Lande der Furcht und Knechtschaft*, in Missionsbote der Schweizer Kapuziner in Afrika, 1928. "Heathen sacrificer", nota bene with a question mark inserted by the missionary in: 7708 or just "traditional healher in: P. Friedbert *Wanderseelsorge im Busch*, in Missionsbote der Schweizer Kapuziner in Afrika, 1936; TNA 61/128 vol II: Edgar Maranta, *Letter to PC E.P. DSM nd [arrived 09.03.1943]*. It seems that 'witchdoctors', if confronted by colonial officials with charges of illicit medical work, claimed that their medicine was only related to fertility (*dawa ya uzazi*), DAK folder 'parishes various shauris': P. Wendelin, *Letter to ARP Gerard, Generalvikar. Iragua 02.06.1955*.
[87] On the Pogoro: Kunibert Lussy, *Die Medizin im Dienste der Mission*, in Missionsärztliche Caritas, 1948; Kunibert Lussy, *Die Wapogoro (Tanganyika-Territory)*, in Anthropos, 1951; Kunibert Lussy et al., *Religiöse Anschauungen und Bräuche bei den Wapogoro*, in Anthropos, 1954.On the Wandamba: Gregorius P. OFMCap Van den Boom, *Die Wandamba (Tanganyika)*, in Anthropos, 1964. Walbert Bühlmann, *Zwischen Mission und Pfarrei*, in Neue Zeitschrift für Missionswissenschaft, 1953, pp. 37-38. Interestingly the term is absent in Eberle's Kiswahli dictionary for the missionaries. Mgombere et al., *Die Geisterhaine und ihre Betreuer*, in Missionsbote der Schweizer Kapuziner in Afrika, 1949; Kunibert Lussy et al., *Religiöse Anschauungen und Bräuche bei den Wapogoro*, in Anthropos, 1954. Ladislaus Siegwart, *Die Arbeitsteilung bei den Pogoro*, 1954, pp. 8-9.
[88] Maia Green, *Priest, Witches and Power*, 2003, p. 116. Lorne Larson, *The Ngindo*, 2010.# p. 18 Wapogoro *Wambui* were also famous across a wider area: TNA District Book, District Office Mahenge, No.1 / Language Notes: Eric Reid, *Some Notes on Witchcraft among the Wapogoro*. For a (long-durée, and rather too speculative) reading of the *Wambui* as an institution that was imported to Ulanga from Ndwewe people, and residing over "royal" spirits see Gloria Martha Waite, *Public Health*, 1992, pp. 224-225; Gloria Martha Waite, *History of Traditional Medicine and Health*, 1992, pp. 68-70.
[89] Jamie Monson, *Agricultural Transformation*, 1991, p. 129; A. T. Culwick et al., *Ubena of the Rivers*, 1935, p. 74.
[90] Sr. Arnolda M. Kury et al., *Frauenklinik St. Anna*, in Missionsbote der Schweizer Kapuziner in Afrika, 1947, p. 94.
[91] A. T. Culwick et al., *Ubena of the Rivers*, 1935, p. 116.

and unhygienic, and because they overestimated their own capabilities. Sr. Arnolda's spite against the local midwives was far from unique.[92] On the contrary, these women served in colonial (missionary) discourse as the personification of the last ally of Satan.[93] It seems likely that Sr. Arnolda's hostile attitude to the local midwives was exacerbated by another struggle over the education of girls (which we will look at shortly). Not least, midwives often also served as *muyago – as the* girls' educators in the initiation schools.[94]

## Science in the negotiation process

In its negotiations with the people, the Mission addressed both colonials and the local people with 'scientific' arguments and with statistics to show how child mortality had been reduced.[95] These numbers and calculations about survival demonstrated the success of the Mission, and also the modernization of African family life and gender roles. Based on such statistical surveys, the Mission argued that the "curbing of child mortality" was the greatest success for the entire of Ulanga.[96] Starting from an assumed child mortality of 70 per cent in the early 1930s, the Mission shows on the basis of Sr. Arnolda's calculations how it reduced mortality in Ifakara to about five per cent.[97] In the 1940s, a missionary doctor in Mahenge, Dr. Adelheid Schuster, re-stated earlier claims by Sr. Arnolda when she analyzed baptism registers and her own practice in Mahenge. She compared monogamous with polygamous and Christian with non-Christian women and assessed the life-time fertility as measured in children still alive at the time of the study. The result was that life-time fertility was largest in the group of Christian women – although they did not give birth to as many babies as the other women.[98] This

[92] Geraldine Forbes, *Health and hegemony*, 1994, pp. 163-168; Nancy Rose Hunt, *Colonial Lexicon*, 1999; Nancy Rose Hunt et al., eds., *Gendered colonialisms in African history*, 1997; Lynn Thomas, *Politics of the Womb*, 2003; Oswald Masebo, *Society, State and Infant Welfare*, 2010; Tabitha Kanogo, *Medicalization of Maternity*, 2001.

[93] Linda Beer Kumwenda, *Training of Female Medical Auxiliaries*, in Le Fait Missionaire, 2005, p. 107. Megan Vaughan, *Curing Their Ills*, 1991, p. 68.

[94] Sidonius Schoenaker, *Hintergründe*, 1965, p. 51; Maia Green, *Priest, Witches and Power*, 2003, pp. 96-100. The Kiswahili term for midwifery (*ukunga*) may be related with works of the same stem *kunga* that have a meaning of teaching secret knowledge in relation to initiation ceremonies. See Kiswahili dictionaries like Kamusi.org. The term is not in Eberle's dictionary.

[95] In adressing government it was important to argue that the work was successful, and statistics were an established genre, see in Michael Jennings, *Matter of Vital Importance*, 2006. There was an even longer tradition in East Africa of establishing demographic calculations of birth rates around mission stations. Juhani Koponen, *Population: a dependent variable*, 1996, p. 32.

[96] Sr. Arnolda M. Kury et al., *Frauenklinik St. Anna*, in Missionsbote der Schweizer Kapuziner in Afrika, 1947. The argument about negative impact of polygamy on fertility was a common one in the Belgian Congo: Nancy Rose Hunt, *Bébé en Brousse*, 1997 [1988], p. 291.

[97] Kunibert Lussy, *Die medizinische Tätigkeit des Vikariates Daressalaam im Kriege*, in Missionsärztliche Caritas, 1947. PADSM 153/3: Hieronymus Schildknecht, *Jahresbericht 1938/39. Ifakara*; Kunibert Lussy, *Die Medizin im Dienste der Mission*, in Missionsärztliche Caritas, 1948; Adelheid Schuster, *Einige statistische Zahlen aus Kwiro über Kindersterblichkeit und Kinderreichtum*, in Missionsärztliche Caritas, 1951.

[98] Schuster proposed to have these numbers published in the newspaper The Tanganyikan Standard, as they were certainly making a good impression of missionary medical work. However, there was not too much need to recommend the practices of the Christian women any more, as "the Christian influence has transpired into ll social circles with Muslim and pagans feeling the positive impact, too." Adelheid Schuster, *Einige statistische Zahlen aus Kwiro über Kindersterblichkeit und Kinderreichtum*, in Missionsärztliche Caritas, 1951; PAL 1061.4: Adelheid Schuster, *Letter to E. Maranta. Kwiro 04.03.1952*.

was certainly an important result, although I am not sure how these statistical relations were adopted by the mothers.

We can, however, be certain that the Mission used such calculations for their propaganda in Ulanga. These numbers addressed an issue that was weighty for Africans. The Mission discouraged, and (where it could) forbade polygamy. But it had to offer solutions to the question of (social) reproduction. The missionaries thus promised, and preached, that a smaller number of births could produce a larger number of surviving children. For women, this was a more convincing argument in favour of Christian families than it was for the non-Christian men, because when the latter had more than one wife, they did not depend all that much on the increased rate of survival of children by each single mother.[99] Men were probably more interested in the survival of the mothers. Sr. Arnolda reported on a practice called *Ulishi*, a sort of a financial compensation due to the family of the woman during childbirth. A maternity home promised safer deliveries and thus also made sense to husbands.[100] We must bear in mind that many men at the time were demanding better health services in general.[101]

The number of births at the maternity unit rose steadily and exponentially. Sr. Arnolda had been in Ifakara for three years before she first assisted at a birth on 12 September1931, and over the next 15 years, a thousand children were born with Sr. Arnolda's help. After that, it took only six years to double that figure and the number continued to rise ever more rapidly. At the time of independence in 1961, the number of assisted deliveries had reached over five thousand.[102] In other words, the number of babies born with Sr. Arnolda's assistance in the entire year 1932 was now born in about a single month in her maternity unit in the new hospital. These numbers can be read to represent an acceleration of birthing in the clinic in general.**[103]** Certainly, the Catholic community now came to the maternity unit for childbirth almost to the exclusion of other birthing practices. Already, for the year 1938/39, 99 of a total of 104 registered newborns into Christian families were born in the maternity unit.**[104]**

[99] There was, however, a system of bride price in place, which would mean that poorer men probably profited more than their richer compatriots. On the brideprice see (as *maheto* or *mahari*): Sidonius Schoenaker, *Hintergründe*, 1965, pp.64, 75-76. Maia Green, *Priest, Witches and Power*, 2003, p. 80-81.

[100] Sr. Arnolda M. Kury et al., *Frauenklinik St. Anna*, in Missionsbote der Schweizer Kapuziner in Afrika, 1947, pp. 94-95; Tabitha Kanogo, *Medicalization of Maternity*, 2001, pp. 81-82. Arnolda and all the other women engaged in midwifery felt an pressure of males to give successful assistance: Franziska Löpfe, *Auf sich gestellt*, 2007, p. 62.

[101] James Giblin, *Divided Patriarchs*, 2000, 181-182.

[102] Rough calculation based on: (PADSM 153/5 >> „50 Jahre Mission Ifakara. St. Andreastag 1911-1961“ handwritten note by P. Gallus, 03.08.1961 PADSM 153/5: P. Gallus Steiner, *50 Jahre Mission Ifakara. St. Andreastag 1911-1961*; *Eine Missionsschwester erzählt*, in Jahresbericht der Schweizer Kapuziner in Afrika 1951, 1951, p. 27; Pater Klemens Hug, *St. Annaheim Ifakara*, in Missionsbote der Schweizer Kapuziner in Afrika, 1938; TNA 450/439: *Letter to Dir. of MS. The Medical Office, Kilosa 01.07.1939*; PADSM 153/4: Hieronymus Schildknecht, *Die Entwicklung der Mission Ifakara 1911-1958*.

[103] Note that the total number of births in the Ifakara area is unknown. But as the population grew, the gross number of births in the area must have risen too.

[104] PADSM 153/3: Hieronymus Schildknecht, *Jahresbericht 1938/39. Ifakara*.

## Reconfiguring Knowledge About Reproduction

The modernization of delivery was only one amongst a number of activities that aimed to reconfigure the practical knowledge applied in the reproduction of the family. We should also remain careful not to accept the missionary claim about reduced mortality, and especially the reasons given for it, too easily. The rates of child mortality must be seen as the result of social and economic circumstances, rather than that of cultural adjustments in birthing and the hygienic improvements brought by a single maternity unit.[105] From the missionaries' perspective at the time, another major factor for child survival was the modernization of infant feeding practices. Birth and the care for children went hand in hand at the St. Anna maternity. We have seen how important the daily rations of food were to the success of the maternity unit and this was a sure sign that patronizing the maternity unit was a way to build an alliance with the Mission. Sr. Arnolda struggled hard against some traditional feeding habits, and by doing so, she also challenged established rituals of social reproduction.

The medicines that the *mbui* and the midwives possessed and dispensed were intended to foster fertility, but their consumption also served to integrate the child into the paternal side of the family.[106] *Shirala/chirala* and the *ubaga* medicine[107] took centrestage, and they were repeatedly administered during the first month of the newborn's life.[108] Both medicines are based on flours and are fed to the child – this was probably part of the objections the sisters had against feeding practices. African feeding habits quickly came under suspicion and were aid to wreak havoc on the chances of infant survival. According to reports by the Mission, newborns received a thick porridge including 'secret herbs' and wild honey in order to flush the digestive system.[109]

We should not be led to think that the Mission primarily tried to intervene in the 'magic' dimension of *shirala*. Rather, it was a combination of a racist perspective on African child rearing together with the influence of nutritional science discourse which thrived in Europe at the time that was at the heart of Sr. Arnolda's practice and of health campaigns in Ulanga in the 1930s. The missionaries in Ulanga had criticized African care for children well before that first Catholic conference on children's welfare in Africa mentioned by the missiologist Beckmann. In Chapter One, we noted the comparison between African and animal child-care in Ifakara from the mid

[105] It is unlikely that Sr. Arnolda's midwifery work was anything as superior to local practices as the mission claimed. Irvine Loudon, *Childbirth*, 1993.
[106] Maia Green, *Priest, Witches and Power*, 2003, pp. 64, 87-88, 96-97. Sidonius Schoenaker, *Hintergründe*, 1965, pp. 50-54. Green reports that elderly people compared shirala to baptism as it creates paternity (p. 64). Indeed Engelberger described it as "Sippentaufe" (tribal baptism) in Aquilin Engelberger, *Unsere Neger*, 1954. I am citing from: Sidonius Schoenaker, *Hintergründe*, 1965, p. 50.
[107] Ubaga is considered as food rather than a medicine in Gogo culture today: Maia Green, *Priest, Witches and Power*, 2003, p. 152note155; Mara Mabilia, *Breast Feading and Sexuality*, 2007, pp. 49-50. On Shirala see also Rudolf Geigy et al., *Mädchen-Initiationen*, in Acta Tropica, 1951.
[108] Sidonius Schoenaker, *Hintergründe*, 1965, pp 50-54.
[109] Adelina Laube, *Gebräuche und Eigenheiten der Negermädchen und Frauen*, in Missionsärztliche Caritas, 1945, pp. 47-48; PADSM Box 153 Ifakara Mission and Parish 4: Sr. Arnolda M. Kury, *Maternity Ifakara*.

1920s.[110] Sister Innozentia felt that many children could be saved from death if only the women would follow her instructions better.[111] Probably under Innozentia's influence, the trope of mishandling of infant nutrition was adopted by the missionary at Kwiro, Wolfram Meyer. In a rush of frustration, he complained about the lack of care for the sick, particularly of children, whose nutrition was irrational and inadequate and, being "artificial" instead of "natural", not tolerated by the bodies of children. These practices bordered, according to him, on infanticide.[112]

Government saw a need for a healthy reform of child care as well.[113] In the mid-1930s, District Officer A.T. Culwick was convinced that if the campaigns against hookworm and for better housing (a Mission initiative in Ifakara) were joined with a third field of activity, namely infant welfare, it would lead to the desirable reduction of mortality rates in Ulanga.[114] In the late 1930s, Geraldine Culwick was the driving force behind a government campaign against the introduction of solid foods and for Encouragement of breastfeeding.[115] As it was popularly believed that the child directly shared the food her mother ate throughout pregnancy, the Culwicks did public anatomical dissections of animals as a part of the campaign in order to show that a foetus was not connected to the intestines of a mother.[116] Culwick felt that the campaign was a big success.[117] The Director of Medical Services himself had printed "several hundred copies of a suitable letter", which were then sent to many recipients in Ulanga. Culwick saw this as a crucial element of the success of the campaign because the written message had stimulated much discussion and positive response.

Missions also relied on the written word. For example, the German missionary doctor, Thekla Stinnesbeck, who practiced in the southern highlands and was most probably in regular contact with her northern neighbours in the Capuchin Mission, had authored a guide to good mothercraft in the early 1930s.[118] Additionally, the Capuchin Mission also used the power of the spoken word: ”now a campaign from the pulpit was started. And when the heathen saw what went on in the Christian community, they followed suit in matters of feeding their babies.“[119]

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[110] *Unsere Mission in Ifakara*, in Missionsbote der Schweizer Kapuziner in Afrika, 1924.
[111] Schwester Innozentia, *Aus den Missionen*, in Providentia, 1929.
[112] Wolfram Meyer, *Poesie und Prosa des Missionslebens [Auszüge aus seinem Tagebuch]*, in Providentia, 1929.
[113] Oswald Masebo, *Society, State and Infant Welfare*, 2010.
[114] Schildknecht had started a campaign for new, "healthy" housing in Ifakara. Houses were rented out to members of the mission community, explicitly as a means against polygamy as well. More than 100 small families were housed like this in 1934. This approach at healthy, well-aired and sanitary housing was seen as exemplary by R.R. Scott, who is reported to have called the Sultan and his advisors and told them that the mission houses were the model for housing in Ifakara. P. Hieronymus Schildknecht, *Weitblickende Hirtensorge*, in Missionsbote der Schweizer Kapuziner in Afrika, 1935; PADSM 153/3: Hieronymus Schildknecht, *Jahresbericht 1937/38. Ifakara*.
[115] A. T. Culwick et al., *Study of Population*, in The Sociological Review, 1938/39. p. 29; A. T. Culwick et al., *Social Propaganda*, in Overseas Education, 1938, p. 103.
[116] A. T. Culwick et al., *Social Propaganda*, in Overseas Education, 1938, p. 103.
[117] A. T. Culwick et al., *Study of Population*, in The Sociological Review, 1938/39, p. 29.
[118] Thecla Stinnesbeck, *Utanzaji wa Watoto Wachanga*, 1932. See for further parallels of her discourse with that of Sr. Arnolda: Thecla Stinnesbeck, *Auf der Frauenabteilung in unserm Eingeborenen-Hospital in Ndanda in Ost-Afrika*, in Missionsärztliche Caritas, 1935.
[119] Kunibert Lussy, *Die Medizin im Dienste der Mission*, in Missionsärztliche Caritas, 1948, p. 13.

In the end, the surest way to promote 'correct ' feeding habits was by bringing young mothers under institutional control. When a mother gave birth at a Mission maternity unit, birthing and feeding was under the supervision of the Mission midwife and the mother could be taught how to feed and suckle her child according to 'modern' knowledge, and even with cow's milk if necessary.[120] Proudly, Sr Arnolda reported that "today we don't find a single mother in the neighbourhood who still shoves porridge into the child's throat from the first day."[121] This change of habits was momentous and must be seen in the larger context that milk took as a symbol of Development. The Mission had established a tradition of giving out food to mothers and children in times of want.[122] As a central pillar to these activities, the distribution of milk towards mothers and children was to become a central element of the Mission dispensary practice (see chapter 10), linking the social welfare of the Mission to the domain of health, but also of gender in the framework of Mother and Child Health (MCH).

## Controlling Fertile Bodies

By now, it has become fairly obvious that the maternity unit was an institutional tool in a larger project which aimed to reform health behaviour no less than gender relations and gender roles. Additionally, it was also linked to a reform of sexuality. Marriage was the ultimate institution which was at stake here. Maia Green has even described the Mission as a 'matrimonial agency' to denote the huge importance of marriage for the Church.[123] The institution of marriage was of the highest interest to the Christian Mission and many studies on marriage customs and the application of canonic law have been written by theologians.[124] Every day, missionaries were confronted with the moral problems which the so-called "wild marriages" of Christian girls posed to them. These problems had far-reaching consequences in Catholic terms: the non-conformity of life as it was lived in Ulanga with Church law and regulations effectively meant that the priests regularly had to exclude many Christians from the Catholic sacraments and send them 'back' into a heathen life, where the hope of salvation was lost. Peter Pels has argued that women in particular were opposed to the Catholic concept of marriage as the morally correct marriage in Christian terms limited their practical means of

[120] Sr. Arnolda M. Kury et al., *Frauenklinik St. Anna*, in Missionsbote der Schweizer Kapuziner in Afrika, 1947, p. 95; Adelina Laube, *Gebräuche und Eigenheiten der Negermädchen und Frauen*, in Missionsärztliche Caritas, 1945, p. 47; Pater Klemens Hug, *St. Annaheim Ifakara*, in Missionsbote der Schweizer Kapuziner in Afrika, 1938; TNA 450/439: *Letter to Dir. of MS. The Medical Office, Kilosa 01.07.1939*.
[121] PADSM Box 153 Ifakara Mission and Parish 4: Sr. Arnolda M. Kury, *Maternity Ifakara*.
[122] PADSM 153/3: Hieronymus Schildknecht, *Quartalsbericht von Ifakara: Pfingsten 1935*.
[123] Maia Green, *Priest, Witches and Power*, 2003, p. 41.
[124] N. P. Kipengele, *Marriage celebration among Wamatumbi and Wapogoro and its relation to Canon Law*, 1964. Kipengele was Bishop of Mahenge from 1970 to 1972

acting under the colonial situation, particularly in the light of absent men.[125] As a consequence, the Church tried to exert control over the flock, in particular over the girls and boys.

A field of particular importance to the Mission was initiation, which entailed a range of moral problems, and curbed Catholic control over females. Initiation, called *Unyago*, comprised of a series of rituals concerned mainly with female fertility and social reproduction. Maia Green discusses the importance of these puberty rites and as a gendered style of education in Mahenge in great detail.[126] These female 'initiation' rites were a matter of great concern to the Mission, because the missionaries knew that during the period of seclusion the girls would receive training in all matters female, including sexuality, and that this period would transform the girls into marriageable women.[127] *Unyago* taught grown-up-girls, called *mwanamwali* (pl./sing: *mwali*) to be wives who could procreate.[128] Missionaries spoke little about the particulars of the *unyago* rituals and teachings, but attacked the period of seclusion of the young girls which was important to the entire process.[129]

Initiation formed a topic of considerable debate in the colonial circles. Unyago and the status of the *Mwanamwali* spurred a considerable debate about the possibilities of transforming African institutions. The matter of these initiation rites had raised an enormous debate in missionary discourse in the German colonial period.[130] In the late 1920s, there was a famous attempt at reshaping these rituals into a Christian practice.[131] Academics felt that even if *Unyago* entailed a sort of genital mutilation (which it did only among some groups in Ulanga[132]), there should be a way to use these ceremonies for the development of the Africans. A view expressed was that "if educational authorities and missionaries were more sympathetic towards the initiation ceremonies, and instead of banning them would seek to utilize them [...] they would be able to lead the people to the necessary reforms without the forceful intervention of authorities."[133] The Culwicks were generally supportive of such attempts at transformation, and they suggested that women could be approached via the *Mbui* in order to modernize

[125] Peter Pels, *Politics of Presence*, 1999, chapter 4. On the whole the mission had not that much impact on the freedom to chose spouses, Giblin claims. "The real impact [...] may have been to provide a new idiom in which mena dn women claimed personal autonomy." James L. Giblin, *History of the Excluded*, 2005, p. 92.
[126] Maia Green, *Priest, Witches and Power*, 2003, pp. 96-104. Pels describes the rites as he believed they existed in Uluguru in the 1930s and 1940s, but it is not so helpful for our discussion Peter Pels, *Politics of Presence*, 1999, pp. 171-180.
[127] Rudolf Geigy et al., *Mädchen-Initiationen*, in Acta Tropica, 1951. Maia Green, *Priest, Witches and Power*, 2003, pp. 96-106.
[128] The "grown-up girl"/"erwachsenes Mädchen" is the translation in the mission dictionary: Erich Eberle, *Kiswahili (2nd edition)*, 1953, p. 109. Maia Green, *Priest, Witches and Power*, 2003, p. 98.
[129] Schoenaker, based mainly on missionary information uses the very negative term "Einsperrungszeit" (period of locking up): Sidonius Schoenaker, *Hintergründe*, 1965, pp. 62-63. He gives no information on the contents of the teachings and the knowledge involved, but names more than describes some of the rituals which involve the public.
[130] Michael Weidert, *Solche Männer*, 2007, pp. 194, 314-317. Weidert also gives a very interesting missionary source transcripted on pp. 431-3: ASO Z. 2.1.32 Abschrift der Chronik von Ndanda Mai 1908-Oktober 1910 (Original: Z.2.1.31), S. 6ff.
[131] Siegfried Hertlein, *Wege christlicher Verkündigung*, 1976, 1983, Vol. II pp. 108-112.
[132] Personal communication Dr. Rolf Diethelm, letter dated Altdorf 5.9.2012. But it did with the Ubena: A. T. Culwick et al., *Ubena of the Rivers*, 1935, p. 344.
[133] *Editorial Notes*, in Journal of the Royal African Society, 1932, p. 90.

motherhood.[134] The Culwicks' ethnographic description of a the transformation from girl to married woman through four ritual stages was quite matter-of-fact and acknowledged the success this system had in permanently instilling the moral principles of gender relations of Wabena culture in the young girls.[135] However, a couple of years later Geraldine Culwick was outspoken about her rejection of the seclusion of girls:

> "there can be no doubt that they go to their bridegrooms far fitter in mind and body than the miserable cowed little creatures who creep out into the sun after years of darkness, and far better qualified to make their contribution to their own and the succeeding generation."[136]

Culwick noted that there was a need for "a new institution [to] replace the old".[137] Missionaries agreed on the health benefits and the need for a campaign and new institutions. Pater Emmanuel postulated: "if we succeed in raising and educating Christian women, in blessing Christian marriages and families then this people will come to strength both in spirit and body."[138] The new institution ultimately was Christian marriage, but there was also a need to have an institution to replace the period of seclusion. We shall see that the girls' schools were to serve as this institution.

## Ideal Women

Such a campaign again positioned the missionary nun in sharp contrast to the 'old' African. The traditional midwives played an important role in the *Unyago*, and the midwife remained an important influence on her protégé throughout her life.[139] As we have seen, colonial governments had begun to develop programmes for the training of indigenous midwifes in the 1910s, even before Sr. Arnolda had started her work. By the late 1940s, it was clear to those in charge of Tanganyikan Government health policies that they needed to train young women rather than the older women in midwifery:

> "The older woman, whilst commanding greater confidence, nevertheless exercises a conservative drag of a pagan era, e.g. she may be a good midwife but she has not yet parted with the ancient custom of hanging up a goat's bowels above the door [...] such a woman has the mothers of the next generation in her hands. [Also] the mature woman who is literate is hard to find." The writer was aware that young girls of maybe 25 years "may not in fact be of much value as midwives, but they will form a nucleus and a base from which the old tribal conservatism may gradually vanish, giving way to a future service of young midwives."[140]

By that time, Sr. Arnolda had already trained a good number of assistants to work with her in Ifakara or in the villages. She was herself part of a movement that wanted to establish new ideas of womanhood in Ulanga. Unlike the established African midwives, she was a professional person who had not borne a child herself. As a woman trying to have a say in social questions of

[134] A. T. Culwick, *Study of Factors*, in East African Medical Journal, 1938/1939, p. 74.
[135] A. T. Culwick et al., *Ubena of the Rivers*, 1935, pp. 344-375.
[136] Geraldine M. Culwick, *New ways for old in the treatment of adolescent African girls*, in Africa, 1939, p. 432.
[137] Geraldine M. Culwick, *New ways for old in the treatment of adolescent African girls*, in Africa, 1939, p. 427.
[138] *Die Schweizer Kapuziner in Afrika. Jahresbericht 1925*, 1925, p. 24.
[139] Rudolf Geigy et al., *Mädchen-Initiationen*, in Acta Tropica, 1951, p. 315.
[140] TNA 10409 vol II: N.N., *File Title!*, Note 20 to MSS of 12.12.1949, signed by TG.S.

reproduction she was, therefore, very different from those women, whose social identity was based on their status as being beyond their fertile years.[141]

Sr. Arnolda was trained in medicine, but also in a spiritual and cultural way as an ideal Christian woman. She combined her professional and social roles, as she was also meant to be an auxiliary to the priest and thus a mother of the Church and a pioneer of the Mission.[142] The ideal women whom the Mission upheld as exemplars were Martha and Mary, as we have seen in Chapter One. Mary, in particular, could serve as a role model to the missionary as well as to African women and was at the centre of the Catholic address to women. The sisters created their own ideals of womanhood as celibate women without families of their own within a powerful paternalist moral economy.[143] That the name of Anna (St Anne) was chosen for the maternity unit in Ifakara was hardly coincidence. The mother of Mary was to be the patron saint of an institution that was the "mother of mothers".[144] The colony, historians have shown, offered new fields, and new challenges for these European women to articulate gender concepts.[145] Interestingly, many of these women left subservient womanly roles for positions with 'male' qualities, including an amount of bureaucratic power and charismatic leadership in public spaces.[146]

A nun was not a biological mother, but the Virgin Mary's core quality in Ulanga, Maia Green, has argued, is precisely her motherhood, and the fact that she suffered the loss of her child.[147] The nuns themselves liked to assume the attitude of social mothers. When they posed for photographs in Ulanga, the nuns are very often depicted with children in their arms, in a sort of Marian pose. Increasingly, they were also photographed with many young mothers and their children. These photos easily bridged the racial divide and represented loving care and physical closeness. A caption on a photograph from the late 1920s used for propaganda in Switzerland reads "Sister with African child. […] She is a symbol of Christian charity in Africa" and presented

[141] Maia Green, *Priest, Witches and Power*, 2003, pp. 105, 117-119. Remember the title of 'Mama' which the missionary sisters were proud of. Sr. Consolata Kaufmann, *Mama*, in Franziskus-Kalender, 1951.
[142] Dana L. Robert, *American Women in Mission*, 1998, pp. 366-367; T. O. Beidelman, *Altruism and Domesticity*, 1999, pp. 113-114; Mary Taylor Huber, *Dangers of Immorality*, 1999. Baldegg sisters carried an identity as pioneers: Schwester Erika Lischer, *50 Jahre Baldeggerschwestern in Tansania 1921-1971 (manuscript)*, (PADSM/Institut Baldegg, 1971), pp. 67-70; Leanne Merrett-Balkos, *Just Add Water*, 1998; Nancy Lutkehaus, *Missionary Maternalism*, 1999, p. 200.
[143] Adelina Laube, *Gebräuche und Eigenheiten der Negermädchen und Frauen*, in Missionsärztliche Caritas, 1945. She comments with some criticism on the isolation of the celibate, childless woman. The issue of celibacy and the building of social alliances with the Catholic Church is nicely presented in Kathleen R. Smythe, *Child*, in Journal of Religious History, 1999. On the concept of social or spiritual motherhood see chapter 1. Andreas Eckl, *Grundzüge einer feministischen Missionsgeschichtsschreibung*, 2009, pp. 134-135; Ulrike Sill, *Encounters*, 2010, pp. 35-46. Andrea L. Arrington, *Making Sense of Martha*, in Social Sciences and Missions, 2010; Jessica Howell et al., *Authority Abroad*, in International Journal of Nursing Studies, 2011.
[144] Hl. Anna resounds, especially in light of the Franciscan background, with the idea of perfect motherhood and the immaculate conception: The Franciscan tradition pushed the idea that St. Anna conceived Maria immaculately, see biographisch bibliographisches Kirchenlexikon http://www.bbkl.de/a/anna_h_m_m.shtml accessed 17.08.2009
[145] Mary Taylor Huber et al., *Gendered Missions*, 1999.
[146] Jessica Howell et al., *Authority Abroad*, in International Journal of Nursing Studies, 2011.
[147] Joan F. Burke, *These Catholic Sisters are All Mamas!*, 1993.

her love as the counterpoint to the work of the colonialist, who pushes the poor heathen into even greater poverty, and makes them deaf for the teachings of salvation."[148]

These pictures transported an image of the Catholic Church as protector of the welfare of women as mothers, both in Africa as well as in Switzerland. At the same time it posited the female body as in need of health, so that it could be fertile.[149]

In being a good educator and protector of mothers, Sr. Arnolda really fulfilled her mission. Sisters were, in the eyes of the Mission, "absolutely needed in Ifakara because they could work in health care, in the school, they could take care of the Church gowns and most of all, they could raise girls to become Christian mothers to their homes."[150] Now, Sr. Arnolda was not working in education, but she contributed to the proto-professionalization of women, and on a broader level she contributed to the modern (re-)establishment of the female world as a modernized domestic life. The Mission in Ifakara constructed a set of new institutions through which it could bring women under their influence and control their behaviour. One of these was a community of the Marian league, which was started in Ifakara on the 15.02.1931, half a year before Sr. Arnolda assisted the first birth in Ifakara, with the explicit aim of abolishing the seclusion of the *mwali* during puberty. In order to prevent "wild marriages", the Mission held, that "all the adolescent or unmarried Christian daughters have to live on the Mission until the day of their marriage".[151] A month later, it was announced that all girls who were pupils at the school must board at the Mission's girls home in a sort of Christian seclusion (called Utawa) during the term.[152] This announcement immediately led to angry negotiations in the Mission's office every day. But eventually the District Officer and also Chief Hassani Njohole conceded that the Mission was allowed to postulate such a rule. In these schools, young women learnt, in Kiswahili, how to become well-educated mothers.[153]

A major element of the girls' training was health. But, even more, the girls were "introduced to the practical chores in the home and family. The family will later be their field of activity." [154] The curriculum of these schools leaned towards mothercraft rather than calculation.[155] The Mission now offered schools for older girls as well. In Ifakara on 4 February 1946, a domestic school was opened that was meant to be attended after primary school. The

[148] PSKO Album Kwiro II: *[photograph] Schwester mit dem Negerkind*.
[149] Wind's argument, that the Catholic female sports movement (in Switzerland) was all about the fertile female body: Regula Wind, *reine Töchter - starke Mütter*, 2008.
[150] *Die Schweizer Kapuziner in Afrika. Jahresbericht 1925*, 1925, pp. 8-9.
[151] The "maraianische Jungfrauen Kongregation Usharika wa B.M." PADSM 153/3: *Chronik von Ifakara. Januar 1931-Pfingsten 1933*.
[152] PADSM 153/3: *Chronik von Ifakara. Januar 1931-Pfingsten 1933*; PADSM 204/Ruaha 1: *Quartalbericht Ruaha, April - Juni 1944*. For a description of Ifakara girls's school with about 70-80 girls from 1933 see: Sr. Berchmans Guntern, *Die Schule von Ifakara*, in Missionsbote der Schweizer Kapuziner in Afrika, 1936. Control was never total, and there were extended periods of holiday during harvest and other periods were agricultural labour was in high demand. *Tawa*, the Mission held, stood for a "stay-at-home, secluded, morally hygienic and devout way of living": P. Laurenz Kilger, *Watawa - schwarze Schwestern*, in Neue Zeitschrift für Missionswissenschaft, 1945, p. 114.
[153] P. Zeno Gschwend, *Kreuz oder Halbmond in der Ulangaebene?*, in Seraphisches Weltapostolat des Hl. Franz v. Assisi, 1934.
[154] P. German Abgottspon, *Schulen*, in Missionsbote der Schweizer Kapuziner in Afrika, 1942, p. 74.
[155] Siegfried Hertlein, *Wege christlicher Verkündigung*, 1976, 1983, Vol. II. p. 31.

subjects were "religion, nursing, naturopathy, care of nurslings and children, knowledge in motherhood, nutrition and housekeeping."[156] By the early 1950s, the Mission had still not succeeded in dissolving the seclusion period. The official strategy of the Mission now was to shorten the period of seclusion to a minimum and then take the girls out of seclusion directly into the boarding school to prevent their going into marriage at the end of the seclusion.[157] This amounted to the explicit replacement of *Unyago* as a rite of passage by the Christian girls' boarding school.[158] The Mission exerted much pressure on the girls. In 1951 the District Officer even stated in the annual report, that:

> "An instance occurred at Ifakara Mission where an attempt was made to compel an African girl how had reached the age of puberty to remain at the Mission against her will and the will of her guardian."[159]

These institutions now stood in the midst of a debate about change and modernization fought directly over the rights to command over individual women. The missionary practice, furthermore, risked driving a wedge between the older and younger generations and even between mothers and daughters, at the same time as it established institutions that were meant to modernize women in the framework of rural development. Although domestic crafts was a well established tradition of the missions, reaching back these classes for older girls and mothers were now called *'maendeleo'*.[160]

## Conclusion

We may, thus, conclude that Sr. Arnolda served as a propagator of modernization, even though she was never the sole actor and nor did she function fully independently as a pacesetter. The biopolitical agenda of the Mission and of the Government strongly overlapped, in their emphasis on the reduction of child mortality, the critique on maternal ignorance and birth assistance, as Nancy Rose Hunt has powerfully shown in her research.[161] If Sr. Arnolda had not engaged in midwifery and maternity services, these fields would have probably been handed over to African women, just like basic health care was put into the hands of the African dressers. We cannot be sure that Sr. Arnolda and the mission chose to invest so much into maternal and child welfare with a strategic intent to counter the influence of Government, or non-Christian African professionals over the total medical market in Ulanga. Even if this was indeed a result of

[156] P. German Abgottspon, *Schulen*, in Missionsbote der Schweizer Kapuziner in Afrika, 1942.
[157] Rudolf Geigy et al., *Mädchen-Initiationen*, in Acta Tropica, 1951, p.303n309.
[158] In Uluguru the Catholic missionaries fought against the rites in a similar way as the Swiss missionaries in Ulanga: Peter Pels, *Politics of Presence*, 1999, pp. 184-187.
[159] TNA 461/27/1: Tanganyika Territory District Commissioner Mahenge et al., *Annual Report Ulanga District 1950 [11.01.1951]*.
[160] Silke Strickrodt, *If She No Learn*, in Comparativ, 2007; Ulrike Sill, *Encounters*, 2010. On the notion of *maendeleo* in Ulanga: Noa Vera Zanolli, *Education Toward Development*, 1971. Pp 203-218. Maia Green, *Participatory Development*, in Critique of Anthropology, 2000. *Das Zauberwort maendeleo*, in ite, 1967; ASML R2T1S2blauO2 Afrika. Tanzania.../Pugu, Msimbazi: Sr. M. Consolata, *Letter to Studer. Msimbazi 27.06.1970*; PADSM Box 17 - Mahenge 5: *Shule ya Maendeleo ya akina mama / Kwiro*.
[161] Nancy Rose Hunt, *Bébé en Brousse*, 1997 [1988]; Nancy Rose Hunt, *Colonial Lexicon*, 1999.

the Mission engagement, the first motive probably was the stabilization of the Christian community through the control of reproduction. Pater Hieronymus Schildknecht stated it clearly when he looked back at the history of the Mission in Ifakara: "Nothing has ever had a more powerful and sustained influence on pastoral work than the maternity service."[162]

From an obstetric point of view, Sr. Arnolda's midwifery practice was not very much better than African midwifery. But her practice seems to have been carried by a movement in Ulanga society which was receptive to her modern practices. In a difficult colonial situation where gender arrangements came under pressure from many sides and tensions between the generations grew, the Mission maternity practice was shaped by and, in turn, shaped the way these changes were articulated in Ifakara. As the missionaries attempted to reconfigure the moral economies of gender, the "major antagonism between the Mission and [elder] women was rarely a debate about differing cultural valuations of gender [...but about] the transformation of girls into female adults."[163] As we looked at the medicalization of motherhood in Ifakara, we also looked at the contribution of medicine to the moral and social programme of the Mission as it was mediated through the female womb. The maternity offered a fundamental service in that it fortified successful mothering. Based on successful childbearing, the Mission argued for monogamy in marriage, against the 'seclusion' of young girls, and emphasized the domestic role of the mother. When the medical Mission medicalized the family and socially reorganized it by subjecting family life to new moral and rational regimes, it also became a catalyst of gender reconfigurations. These new practices branded modernized birthing and child care "ya kisasa" as a gendered profession, with 'mothers' acting in the domestic sphere and the "sister Mother" acting in the public space of the Mission, more precisely in girls' education and in nursing. Mary, the Catholic ideal mother and focus of Catholic female spirituality, was brought to Ulanga as the quintessence of motherly values and morals. It has, as Maia Green, shows, left a deep imprint on Catholic women who adopted the figure of Mary in their own ways.[164]

Although the Mission postulated new models of womanhood, the maternity unit partly established a Christian way of living. There is no question that birth at the clinic was the typical entry into the life of a Christian for the second generation of Christians. At the same time, we do not see that it was considered an exclusively 'Christian' way of giving birth: it was the 'modern' way. In 1948, medical services at the Ifakara maternity unit and the dispensary seem to have been quite popular across a substantial section of the population, and the Mission considered this as a major change and success.[165] Women in Ulanga were increasingly prepared to use these kinds of services. We can assume that they did so with a good degree of agency. In the early

[162] PADSM 153/5: Hieronymus Schildknecht, *Vorgeschichte zur Gründung der Mission Ifakara*.
[163] The quote is from Peter Pels on Uluguru women, but are likely to apply in Ulanga, too. Peter Pels, *Politics of Presence*, 1999, p. 160.
[164] Maia Green, *Priest, Witches and Power*, 2003, pp. 70-71.
[165] Kunibert Lussy, *Die Medizin im Dienste der Mission*, in Missionsärztliche Caritas, 1948, p. 12.

1950s Ladislaus Siegwart reported how young women were not only giving birth the European way and resisting to some degree to enter polygamous marriage. Many of them also came to Church in modern dress – a fact which was not well regarded by the more conservative missionaries.[166]

Sr. Arnolda's engagement in birthing and child nursing shows the Mission's multifaceted contribution to governmental knowledge about rural health care. The Mission maternity established and anchored the idea of modern medical institutions as purveyors of (social) reproduction and that bureaucratic institutions could intervene in fertility in intimate ways. It also constructed a gendered form of development discourse with health as a prime field of activity and with compassionate care in the service of the offspring and future generation as a moral quality. The maternalism pushed by the Mission put women at the centre of medical and welfare policies and established a field of social development addressing women and children, rather than the male breadwinner.[167] A number of historians have shown how women were constructed as a sort of natural public health agents in the years discussed here.[168] The issue of public health was 'skirted', as Birn calls it.

As public health and a biopolitical programme in the name of 'civilization' were produced by addressing women, this also entailed a specific process of institutionalization and professionalization, by establishing 'skirted' institutions wherein a specific educative discourse was practiced. We will look at the dispensaries again in chapter 10 to see how the educative character of these institutions was carried into the post-independence age of Ujamaa. In terms of professionalization, from the 1930s to the 1950s the St. Anna maternity unit was a place where new people took over the tasks of midwifery, and a new group of young, female proto-professionals saw the light. These proto-professionals based their authority on the new knowledge and practices of birthing – but this knowledge was not only technical. The maternity constructed a tradition of 'care' in an institutional way.[169] This institution was made up of technical skills and knowledge and professional values that contributed to the maternalist set-up for the moral economy of welfare in the caring institutions themselves. It was an institution which took responsibility for the people, through a long-term local presence, a system of patronage that incorporated long-distance networks, and acted through female networks. This was not only a mission that 'made mothers', it was also a mission that became 'feminized' in terms of the moral values it carried. As the mission propagated Christian female domesticity, it

[166] Ladislaus Siegwart, *Die Arbeitsteilung bei den Pogoro*, 1954, p. 24, 34, 169.
[167] Susan Pedersen, *Family, Dependence, and the Origins of the Welfare State*, 1995 [1993].
[168] Lenore Manderson, *Sickness and the State*, 1996, p. 228.
[169] This also means that 'care' was not foreign to colonialism, even though there is no question about its racial underpinnings. Liz Walker, *Colour White*, in Ethnic & Racial Studies, 2005. Nancy Rose Hunt, *Colonial Lexicon*, 1999, pp. 246-248. For recent scholarly debates about 'care', a term that denotes reproductive labor which is both 'domestic' as much as affective or emotional, see: Frigga Haug, *Das Care-Syndrom*, in Widerspruch, 2013; Michael A. Slote, *The ethics of care and empathy*, 2007; Christa Schnabl, *Gerecht sorgen*, 2005, pp. 9-17. Care is not 'modern' though, for local concepts of care in Mahenge see Maia Green, *Priest, Witches and Power*, 2003, p. 117.

also positioned the paternalism of the Mission within the moral space of the post-childbearing woman, a space which was, according to Maia Greens research, filled with the capacity to suffer for the well-being of others. Sr. Arnolda became a mother of Ifakara, or even Ulanga.

All this shows how health created intimate entanglements in the history of colonialism and post-colonialism and how the Mission became a node where links were mediated.[170] The maternity unit in Ifakara reconfigured the experience of birthing as much as it reconstituted a global discourse on scientific motherhood.[171] The processes of modernization we discussed in this chapter reflect a combined effort to reform social reproduction by addressing issues of health, and making modernized health care relevant to a woman's life. The Mission would really work through the individual body, and even struggle over that body. The structure of this entanglement opened channels for knowledge on female livelihoods and African medicine to flow in both directions. As a colonial medical officer stated:

> "No mother would think of entrusting her sick child to the care of a man who obviously knew nothing of the four great causes of disease: spirits of the dead, witchcraft, breaches of taboo, and infidelity of a married couple."[172]

All this paints an image of a rather intimate and differentiated encounter in the colonial situation. It is in this sense also that Mission medicine became 'colonial' in the maternity. It certainly presented its achievements with pride to the colonial Government, yet at the same time, the maternity unit and the work for women's and children's health tried to convince the Africans as well. The Mission proudly presented its maternity hospital and the "special emphasis it laid on infant feeding" to visitors from Government.[173] At the same time, it also presented itself as a gift to the Africans which could be, eventually, turned it 'our house'. In the story narrated here, there is an element of negotiation and openness, of close interaction and truly local agency.

Sr. Arnolda apparently was quite successful at building the trust needed so that she was entrusted with the sick or newborn child.[174] Sr. Arnolda's practice relates to a medicalization of childbirth and childrearing practice that has both a repressive and a liberating side.[175] Women who went through the bodily experience of delivery participated in this process and were demanded specific services. This was even more the case as there were no means to push a fast medicalization across the whole society.[176] Clearly, it argues for a "'demand-oriented' account of the process, which seeks to view it not as the imposition of ready-made structures on a passive

[170] Anna Laura Stoler et al., *Tensions of Empire*, 1997; Sebastian Conrad et al., *Jenseits des Eurozentrismus*, 2002. Rebekka Habermas, *Mission global*, 2014.
[171] Margaret Jolly, *Colonial and Postcolonial Plots*, 1998. Mary Taylor Huber et al., *Gendered Missions*, 1999, p. 18; Susan Thorne, *Missionary-Imperial Feminism*, 1999, p. 45.
[172] Humphrey A Gilkes, *Native Customs in Africa and the Medical Officer*, in Transactions of the Royal Society of Tropical Medicine and Hygiene, 1934, p. 317.
[173] 3957 TNA 450/439: *Letter to Dir. of MS. The Medical Office, Kilosa 01.07.1939*.
[174] See for the importance of trust in mother and child health: Michael Jennings, *Matter of Vital Importance*, 2006, p. 246; Walter Bruchhausen, *Practising Hygiene*, in Dynamis, 2003, 109-110.
[175] Linda Beer Kumwenda, *Training of Female Medical Auxiliaries*, in Le Fait Missionaire, 2005.
[176] This was even a problem in industrialized Europe Lara Marks, *Metropolitan Maternity*, 1996, p.292.

populace, but more as a dynamic and dialectical process involving changing patterns of demand as well as the provision of medical services and the fixing of medical norms.[177]

[177] {Jones, 1987 #4636@ p. 57-58} Apple has argued a strong case for mothers who 'actively engaged in the transformation of women's roles and the development of modern motherhood in the US." Rima Dombrow Apple, *Perfect Motherhood*, 2006, p. 3.

# Chapter 6 Mission, Doctors and Hospital Medicine

In 1939 the Catholic Apostolic Vicariate of Dar es Salaam took over the Government Hospital in Mahenge as a Mission Hospital. Although the Mission had referred to many of its medical establishments run by Baldegg sisters as 'hospitals', this was effectively the first medical establishment with a clinical practice exercised by academic medical doctors, which can be considered a hospital in the modern medical sense. The road to this institution was long and full of obstacles and ended abruptly with a great disappointment. The five years of the mission doctors' service for the Mission, and the years that followed, were rife with endless conflict between Bishop Maranta and some of the Mission staff in Mahenge/Kwiro on the one hand and the Mission doctors, Alois and Maria Gabathuler, on the other.

In 1946 Alois Gabathuler, whose wife had given up medical practice for some time already, went even so far as to petition the *Agenzia Fides* [sic!] at the Vatican to rule against Bishop Maranta.[1] This was just one step in a long struggle, but it was a viciously countered one by Bishop Maranta. Maranta wrote that the doctor had been a great disappointment for the Mission. He had, according to the harsh statement of the Bishop, not assisted in strengthening the medical knowledge of the entire Mission, including its nurses in other Mission stations, but had damaged it by his eagerness about surgery ("Operationseifer") and also his ardent love for the Nazis ("glühende Naziverehrung").[2] One of Gabathuler's main opponents in Kwiro/Mahenge had been P. Gerard Fässler, who had been the Vicar of the Diocese and Rector of the seminary in Kwiro. Maranta asked P. Gerard to add his perspective to that of the two missionaries, P.

[1] The issue fought explicitly at this point was Maranta's refusal to cover the full amount of the doctors' cost of returning to Switzerland. This document can be found in various archives, the only place in Tanzania probably is: DAK folder "Briefe verschiedener Herkunft": Alois W. Gabathuler, *Eingabe Dr. med. Gabathuler an die Agenzia Fides, Vatikan*. That Gabathuler sent his case to the Agenzia Fides, the Vatican's news agency, instead of the Propaganda Fides cannot be explained, but it is quite clear that he wished to lodge a court case, not a public complaint.

[2] PAL Sch 1061.5 Mappe 2: *draft of Opposition [to Agenzia Fides, Vaticano] DSM 28.06.1946, nd*; PAL Sch 1061.5 Mappe 1: Apostolisches Vikariat DSM et al., *Opposition [to Agenzia Fides, Vaticano] DSM 28.06.1946*.

Kunibert Lussy and P. Guido Käppeli, whom he suspected to come in testimony pro Gabathuler.[3] P. Gerard gave a lot of the background and painted an image of Gabathuler as a notoriously (P. Gerard wrote "pathologically") complaining, ranting and raving personality. P. Gerard described Gabathuler as not having the real calling to be a Mission doctor, and as a financially self-interested, very presumptuous person, who had associated with the "foes of the Mission" (which meant, in particular, A.T. Culwick). Gabathuler was seen as trashing the reputation of the Mission because he was notorious for speeding his car on Ulanga's roads, because he scolded the Bishop in his absence, because he made derogatory remarks about Pope Pius XI's state of mind and Church policies in general, and – as the World War continued to rage – because he was reportedly took a pronouncedly anti-British political stand.

However, at the core of the disputes was more than merely a conflict with Gabathuler as an individual. This chapter tries to look at the conflicts as they laid bare the internal institutional processes of the missionary enterprise at the time it was becoming professionalized. At the moment of Gabathuler's departure for Tanganyika, P. Ansgar Häne, a former Tanzania missionary with a long-standing interest in medicine and now the Mission propagandist of the Capuchins, published a lucid article in support of professional Mission medicine in the *Missionsbote*. Laying out the field of conflict in a comparably straightforward manner, he took heed of the fact that Bishops at the head of Missions did not like to engage laypersons in their Missions, and noted that many missionaries might not agree with his position. But he still held that extending Mission medical services based on the Mission Doctor was more urgent than new financing for new church buildings.[4] Mainly it was a friction between different branches of the Mission within a very narrow community that became personalized. Friction existed between the Mission school, which P. Gerard headed at the time, and the medical aims of the two doctors, the husband and wife Gabathuler-Leins. The first big conflict in Mahenge erupted when Gabathulers were asked to care for the pupils in the Mission schools, and to arrange their working times around the school teaching time-table. Maria Gabathuler objected and said to the effect that they had come to convert "the Heathen", not to wait on the Catholics in the school. Years after this encounter, P. Gerard held that he could not understand Maria Gabathuler's reasoning. Was the priest really blind to the possibility that the Gabathulers had imagined their work as a display of a sort of 'heroic medicine of wonderful powers that could convert Africans descending from the bush towards Catholicism' an less as a work consisting of sustaining a Mission structure by privileging a future Christian elite with comprehensive health care almost as if they were private practice patients. Could the doctors on the other hand have been so blind

[3] DAK folder "Briefe verschiedener Herkunft" - Corr between Bishop Edgar Maranta and Provicar Gerard Fässler...1945-55: Gerard Fässler, *Letter to Bishop Maranta. Tosemaganga, 11.05.1946*.
[4] P. Ansgar Häne, *Missions-Arzt. Ein paar fachliche Erwägungen zu einem Problem*, in Missionsbote der Schweizer Kapuziner in Afrika, 1938.

as not to understand the historical role medicine played in the survival and stabilization of the seedlings of a rather small Catholic elite community in Ulanga?

What this chapter tries to elucidate, through a careful reading of the infighting taking place at Mahenge/Kwiro, is the structural dimension of a conflict that seems to be one of personal dissonance at first sight. The issue at stake was the role and the position of the medical doctor in the Mission. Twenty years into Swiss Mission work in Ulanga, was Mission medicine a service whose aim was to assure that the current and future (spiritual) leaders of the Catholic Church enjoyed full health? Or was it to prioritize a more secular and public kind of medical service for the general population wherever it was needed most and could contribute to the professional esteem of a medical person. And how were resources and authorities to be assigned to the spiritual and the secular arms of the Mission?

As a background to these debates, the chapter will first look at some fundamentals aspects of secularization and at the way in which leprosy care work in Tabora in the 1930s changed. It shows that problems of the medicalization of welfare had entered the Mission world of experience even before the arrival of the missionary doctors. The third part shows the inclusion of the doctors into Mission services and the fourth section will discuss the cooperation between Mission and Government in providing hospital health care at Mahenge and the conflicts within the Mission about the character and role of medicine as a part of the Mission enterprise. We will also have to look at the story of Dr. Schuster, a third doctor in the service in the Capuchins in order to see how some of the issues were structural rather than personal, and how this led to the low point of Capuchin medical engagement in the second half of the 1940s.

## Medicalization, Professionalism and Secularization in a Catholic Context

When I speak about medicalization in this chapter I take heed of Niklas Rose's warning of the "cliché" by which he means that the term has come to denote that something "suspect" and "illegitimate" is part of the history of medicine. Certainly 'medicalization' cannot substitute writing complex and multilayered histories of the role of medicine in society.[5] Medicalization in the following should be read in a 'neutral' sense meaning that the logic of a medical culture and expertise was exerting influence on a social fact. Medicalization, then, is narrowly tied to the professionalism of doctors.

Professionalization is another of the key terms in medical history. Flurin Condrau has pointed out that Freidson's study on the medical profession has gained cult status, and indeed it

[5] Nikolas Rose, *Beyond medicalisation*, in The Lancet, 2007.

has become the reference theory on 'professionalization' in general.[6] Freidson put the issue of 'autonomy' at the centre of what a profession is.[7] Thinking about professionalization teaches us to reflect about the social binds of science and the politics of expertise and in the making of the medical market. And, as Steven Feierman has proposed, professionalization entails not only the "struggle to establish control over medicine" (and one must add medical institutions) but also to establish "cultural authority".[8] Murray Last has drawn on that theoretical body, but argued that in Africa there was no profession of doctors before decolonization, because doctors had divided allegiance, as colonial administrators, or as missionaries.[9] Yet such an argument is hardly productive as it fails to see how medical professionalism was constructed under exactly these conditions. What follows shows that Catholic mission doctors actively sought to constitute a profession much earlier, and that the allegiance to medicine was a crucial element of the politics. John Iliffe's understanding of 'professionalism' as highly ambiguous, embracing "specialized knowledge, altruistic service, thirst for power, and blatant self-interest," cuts to the point.[10]

My use of 'secularization' does not seek to further contribute to the theory of secularization. Particularly in the German sociology of religion, the term 'secularization' is seen in Max Weber's sense of the 'disenchantment of the world' and the manner in which this influenced individual life. Contrary to this, I use the term in a very materialist sense that is considered, by scholars of religion, as 'castrated', because it is a perspective that foregrounds declining religious authority and expertise.[11] My take on secularization is little concerned with individual practice of religiosity and spirituality. In this chapter I am, furthermore, little concerned with the question of the priority of physical over spiritual aspects of healing in the practice of mission medicine. What is of interest in the following is the issue of authority of knowledge that is grounded in religious terms and based on a church hierarchy, versus knowledge that is based on scientific medical professionalism. According to Christoffer Grundmann, in the 19th century clergy was up against much of the rational-scientific worldview taken by healing.[12]

Recently Patrick Harries and David Maxwell have brought to light the "missionaries as scientists" and their contribution to scientific knowledge in and about Africa.[13] This research reminds us not to think of scientific knowledge as a one-way process modernizing backward clerics through a process of secularization. Mission medicine was an important field within these

[6] Eliot Freidson, *Profession of Medicine*, 1988. Flurin Condrau, *Patient's View Meets Clinical Gaze*, in Soc Hist Med, 2007, p 531.
[7] For a discussion of Freidson and other theories of professionalization and an approach that has been influential in my training see: Claudia Huerkamp, *Ärzte und Professionalisierung*, in Geschichte und Gesellschaft, 1980; Claudia Huerkamp, *Aufstieg der Ärzte*, 1985, in particual pp. 16-18.
[8] Steven Feierman, *Popular Control*, 1986, p. 205.
[9] Murray Last, *Professionalisation of African Medicine*, 1986, pp. 9-10.
[10] John Iliffe, *East African Doctors*, 1998, pp. 3-5.
[11] Manuel Franzmann et al., *Einleitung*, 2006, in particular pp. 11-15. An example of an authority-focused approach, considering himself to be a 'radical' is Mark Chaves, *Secularization as Declining Religious Authority*, in Social Forces, 1994.
[12] Christoffer H. Grundmann, *Gesandt zu heilen*, 1992, pp. 124-125.
[13] Patrick Harries et al., *Spiritual in the Secular - Introduction*, 2012.

secular activities that produced and disseminated new knowledge.[14] Mission medicine believed in the power of science and rationality, as Terence Ranger has argued. The medicine and the hospital was a "weapon because of its superior scientific and rational validity [... and] instilled time sense, work discipline, sobriety - those invaluable preconditions of rational thought and action."[15] Looking at the same missionary organization (the Anglican UMCA) Charles Good has added though that the practical (secular) problems, the lack of funding, staffing etc constituted an "institutional malaise" which made such modernization an uphill battle.[16] But this exactly describes the environment in which 'rational' medical services came to be established in rural Africa as a process that contained the conflicts between different shades of science-based and religion-oriented approaches within Missions.

## The Capuchins and secularization in the mission hospital

From the late 1930s medicine became a topic of ever greater importance to the Capuchin Mission. With the entry of academically trained medical doctors, the organizational structures of the mission were tested: how would they integrate the secular world of medical science into their priorities and hierarchies. What happened was not simply secularization as in 'enlightened rationalization', but a process that challenged the way the Mission, as a source of the Church, arranged its relationship both to the professional culture and discipline of a secular science and to the secular state. Such a process was extremely complex as it brought the monk in charge of a religious school who trained the future clergy into conflict with the Mission doctor who had the habitus of a member of the medical profession as well as that of a lay missionary. But let us not forget, it was a process of negotiation that played itself out in an organization that already devoted much of its energies to the secular serving the spiritual. The Catholic missionary-scientists were steeped in an intellectual tradition of the *Kulturarbeit*, which positioned all such secular, scientific knowledge in a sphere that served to reinforce the authority of the Church. Catholic scientists, according to Harries, were seeking to control disciplinary boundaries to that aim.[17] To a Catholic doctor like Gustave Clément, who served as the vice-president of the Catholic Swiss Association for Mission Medicine, there was little contradiction between the sciences and religion, as he followed the dictum of Théodore Branly, a famous scientist and exponent of the Parisian *Institut Catholique*: "science is an effort towards the creation; religion an effort towards the creator."[18] Thus, when we look at the Catholic intellectuals who are the protagonists in this chapter, we must take this as the limits of the analytical field of

[14] David Maxwell, *Writing the History of African Christianity*, in Journal of Religion in Africa, 2006. Norman Etherington, *Education and Medicine*, 2005.
[15] Terence Ranger, *Godly Medicine*, 1992, p. 259.
[16] Charles M. Good, *Steamer Parish*, 2004, p. 309, also chapter 309.
[17] Patrick Harries et al., *Spiritual in the Secular - Introduction*, 2012, pp. 14-15.
[18] Pierre Jacquat, *[Obituary] M. Le docteur Gustave Clément. Médecin en Chrétienté*, in Missionsärztliche Caritas, 1940.

'secularization': there was no debate that the last instance was the Creator – but there was much disagreement amongst Catholics as soon as the authority of the Church was thrown into the ambiguities of professional politics.

Some clerics for many centuries had been minute observers of nature's work, and missionaries were very aware that it was technology, and not least medicine, that made their enterprise viable at all.[19][20] Technology had two aspects. Not only did it offer a tool to the Mission to function as an organization; materialized in commodities, technology also held a promise to "stir desire" in the African.[21] The hospital at the beginning of the 20th century was almost an archetype of a technical miracle.[22] By that time, the hospital had also been the primary location for the processes of 'secularization' and 'medicalization'. The hospital is steeped in a monastic tradition of *caritas*, and poor relief.[23] Decades before Foucault's studies on the clinic, the doyen of medical history, Henry Sigerist, had pointed out how hospitals were 'medicalized', moving from being charitable to medical.[24] Sigerist's former assistant, Erich Ackerknecht has extended the argument in his study on the Paris hospital.[25] In recent years that master narrative has come under critical review in medical history, as the hospitals never get rid of all cases of poor patients, nor were all practices entirely medicalized.[26] In the Mission hospital, medicine can hardly be separated from religion.[27] Not least, if one sees it from a patient's point of view: for those seeking the hospital, the missionary character of the institution could be seen as the "mainspring of success".[28]

By its very essence as an institution, the hospital was bound to carry conflict into the Mission. The hospital was the main focus not only of medical work for the Missions, as Bruchhausen shows[29], but also of medicalization and secularization. Not least, this was because it needed academically trained doctors to run it and it had an impact on the professionalization of nursing. At the turn of the 20th century secularization and scientification of nursing had propelled a new process of professionalization.[30] An important aspect of the construction of nursing as a science-based and rationally organized discipline was that doctors had gained authority in matters of nursing and over nursing and healing in general.[31] In Africa missionary organization and nurses were active drivers of professionalization. For the comparatively well-

[19] cf Charles M. Good, *Steamer Parish*, 2004, pp. 44-46.
[20] Jacalyn Duffin, *Medical Miracles*, 2009, p. 185.
[21] Jean Comaroff et al., *Twenty Years After Of Revelation and Revolution*, in Social Sciences and Missions, 2011, p. 161-162.
[22] Joel D. Howell, *Hospitals*, 2003, p. 508.
[23] Guenter B. Risse, *Mending Bodies*, 1999, e.g. on p. 347. Gisela Drossbach, *Hospitäler*, 2007. Lindsay Granshaw et al., eds., *The hospital in history*, 1989.
[24] H. E. Sigerist, *An Outline of the Development of the Hospital*, 1936, p. 573.
[25] Erwin Heinz Ackerknecht, *Medicine at the Paris hospital 1794-1848*, 1967.
[26] Othmar Keel, *Politics of Health*, 1985, pp. 219-220; Mark Harrison, *From Western Medicine to Global Medicine - Introduction*, 2009, pp. 4-5.
[27] Walter Bruchhausen, *Medicine Between Religious Worlds*, 2009.
[28] Anne Digby, *Medicine and Witchcraft*, 2009, p. 238.
[29] Walter Bruchhausen, *Medicine Between Religious Worlds*, 2009, p. 172.
[30] Alfred Fritschi, *Schwesterntum*, 2006 [1990], p. 47, 51-53, 158.
[31] The history of midwifery is a particular case in point: Catherine Balmer-Engel et al., *Schweizerischer Hebammen-Verband*, 1994, pp. 24, 34ff.

researched case of South Africa nursing historians like Shula Marks, Helen Sweet and Anne Digby have highlighted the importance of missionary institutions for the training of nurses, both secular and religious.[32] In particular, concepts of gender and disciplined work ethics were infused into secular nursing.[33] To some degree the investment in nursing allowed the Mission to infuse some of its moral and spiritual values into the medical. Where the medical touched on care, a Mission could push the human element in medicine: the need for care and compassion and how they could be practiced in a scientific, rational, even capitalist world.[34] Before we delve into the politics of hospital medicine, let us look at how the Mission experienced medicalization in the 1930s and 1940s in its most traditional field of bodily care in Ulanga, the care for leprosy sufferers.

## The Leprosy Camp Tabora and Failed Attempts at Medicalization

During the 1930s and 1940s Tabora, the village for victims of leprosy outside Kwiro/Mahenge, was a place whose fate was caught in shifting policies, swaying between the approaches of institutional care and biomedical treatment. It shows how the shifts in treatment regime policy and medical administrative policy, welfare and *caritas* turned the camp into a rather unsatisfying and sad location where the rights of inmates, patients and their family were marginalized and remained insecure. In the course of events, the mission did not act as a powerful pressure group with a clear aim. On the contrary, its own interest in leprosy work in Tabora became diffuse: the Mission not only lacked state-of-the-art medical knowledge and resources, it almost looks as if the Mission lost interest in advancing the leprosy victim' community as a beacon and stronghold of Christianity. The Tabora story tells a story very different from Vongsathorn's recent account about Uganda, where leprosy villages concentrating on palliative care were run by Mission doctors and were "showcases" of the civilizing mission in the 1930s and 1940s.[35] The Mission in Ulanga did not drop the leprosy village entirely, however. It continued to contribute to the upkeep of the institution because it seemed to perceive sustained obligations of the moral and probably personal kind. This highlights the crucial conflict: the Mission's *caritas* tradition, and to some degree also the humanitarian feelings of Government officials, would not simply wane when Government policies made care and welfare dependent on the prospect of a successful chemotherapy. Nevertheless, when medicalization

[32] Shula Marks, *Divided Sisterhood*, 1994; Martina Egli et al., *Mothers and Daughters*, 1997. Helen Sweet, *Mission To Nurse*, 2013; Helen Sweet, *Wanted: 16 Nurses*, in Nursing Inquiry, 2004.
[33] Relinde Meiwes, *Kathoische Frauenkongregationen*, in L'Homme, 2008, p. 60.
[34] E. Von Dietze et al., *Compassionate care: a moral dimension of nursing*, in Nursing Inquiry, 2000. Biswamoy Pati, *The social history of health and medicine in colonial India*, 2009, pp. 88-136. Christa Schnabl, *Gerecht sorgen*, 2005.
[35] Kathleen Vongsathorn, *First and Foremost the Evangelist*, in Journal of Eastern African Studies, 2012. Vongsathorns research, like my own, highlights the broad range of conflicting voices on leprosy policy in the colonial administration of Uganda.

materialized in the form of such policies it seriously reduced the livelihoods of those people in Tabora, whose lives had been tied to the place in the previous decade.

In chapter 1 we have seen that Tabora had been a great step in the institutionalization of welfare and medicine in the Mission environment. The Mission had pushed a concept of village settlement and economy and it had taken a first step towards medicalization, when it introduced regular injection services with the assistance of colonial Government.[36] But they had also postulated a policy that kept the camp open to everyone seeking its assistance, most probably in the hope that a community of Catholics or people depending on the Mission for help would develop.

But the Mission never gained full control over the economy of the Leprosy villages, nor over the lifestyle or morals within the communities. Giving food and clothing was a means to make the villages autarkic by adding the welfare component that was not available in an otherwise subsistence economy in the village. The idealized notions of a closed village overlooked the dynamics of local economies. It understood little of the complex agricultural systems which depended on the combination of different ecological systems. Not least, it also underestimated the will and the power of Africans to sustain social networks of kin and alliance. Villagers would regularly leave Tabora village for social festivities in other places. The idea of creating a configuration in which villagers of Tabora were integrated exclusively into a Mission and state welfare system, underestimated the agency and the agenda of those who suffered from leprosy.[37]

## Debating segregation

In the early 1930s Tabora was a place for leprosy patients that was neither the only place where they lived, nor was it exclusively settled by leprosy sufferers, or even sick people. Joining a general discourse about the failure of segregation policies, P. Jesuald regretted that the Government had opted for a system of voluntary segregation. He claimed that "a reorganisation of leprosy care is much needed" seeing that only 270 out of roughly 500 people afflicted with leprosy in Mahenge lived in the Tabora camp and profited from the "outright wonderful efficacy" of the injections.[38] If sick people in the camps were difficult to control, healthy inhabitants were really independent. From the beginning, the Mission fathers had been unhappy with the presence of large numbers of healthy people in the Tabora settlement, living in close quarters

[36] DAK folder "Archbishop DSM Yan 61-Mei 65" [misplaced document in this folder?]: P. Werner *Bericht über die Aussätzigenkonferenz in Daressalaam am Osterdienstag, 19.04.1927*; TNA 450/34/3 James Septimus Armstrong, *Letter MO Mahenge to Dir Med. Services. Mahenge 19.06.1929*; TNA 450/34/3 A.M. Clark, *Letter PC E.P. to DO Mahenge. 06.06.1929*; TNA 450/34/3 H. Rayne, *Letter DO Mahenge to PC E.P., 20.05.1929*.

[37] In Kipatimu there was much complaint by P. Fischli, who succeeded P. Werner, and who took over in Tabora in 1932, about the ungrateful lepers. P. Fridolin Fischli, *Assisi bei Kipatimu*, in Missionsbote der Schweizer Kapuziner in Afrika, 1931; P. Fridolin Fischli, *Gruss aus Kwiro*, in Missionsbote der Schweizer Kapuziner in Afrika, 1932.

[38] P. Jesuald Loretz, *Ein Gruss von den Aussätzigen*, in Missionsbote der Schweizer Kapuziner in Afrika, 1934.

with leprosy patients. Therefore, to an unsuspecting European visitor, the village of Tabora did not even look like a leprosy camp.[39] On the face of it, the discourse on segregation was a very medical discourse, but to the Mission it was a matter of morals, as read against a foil of values about family and hygiene.[40] In the eyes of the missionary, villagers married too easily and such behaviour elicited a range of moral discussions which neatly tied in with Christian moral concepts of disease causation that were particularly strong in the case of leprosy.[41] The missionary ended with a discussion of African fatalism, in a tone of cultural and moral racism, but also by acknowledging that administrative practices failed in view of idiosyncratic social practices.

A matter of particular worry was that women followed their sick husbands into the camp, and that children lived with their parents.[42] As a consequence, the Mission kept propagating the separation of healthy children from their leprous parents. This policy highlights the point at which the values of family politics conflicted with the saving of children. Running orphanages was an old-time precept of the Mission and of the Catholic Church.[43] It was suggested as early as 1926 that the children of leprosy patients be placed in an orphanage and their parents be allowed to visit them "from time to time".[44] In the 1930s this debate acquired a new fervor. By 1934, a number of children had inherited the plots of their parents and had become residents in Tabora. The administration wanted these healthy people to leave with some compensation, and they hoped that the Mission fathers would be the ones "to suggest, cajole or insist that children shall go."[45] At the height of the debate, a Government official felt that what should be done as a minimum standard was to compulsorily remove children from leprosy patients and hand them over to Mission stations for maintenance with aid from the Government.[46]

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[39] Sr. M. Valentina, *Das Heim für die Epileptischen bei der Missionstation Kwiro*, in Missionsbote der Schweizer Kapuziner in Afrika, 1935/6, p. 185.

[40] This can be seen very well in documentation on Kipatimu: PADSM Box 171: R.C. Mission Kipatimu et al., *Kipatimu. Leper Settlement. Correspondence with Kilwa District Office 1927-1950*. In 1937/38 the mission complained about "bad customs". It becomes clear that the Mission intruded in internal familal matters (not the least being the institution of marriage) and hoped to secure the colonial Government's support against polygamy (notes and letters not clearly dated, 1937-1938, one note "sent away" on 19.12.1938).

[41] P. Jesuald Loretz, *Bei den Armen Gottes. Erlebnisse eines Aussätzigen-Pfarrers*, in Missionsbote der Schweizer Kapuziner in Afrika, 1933.

[42] Veit Gadient, *Ein Stündchen bei den Aussätzigen*, in Missionsbote der Schweizer Kapuziner in Afrika, 1932. An example of such a family history in: P. Jesuald Loretz et al., *Aus einer afrikanischen Familienchronik*, in Missionsbote der Schweizer Kapuziner in Afrika, 1935.

[43] Recently Swiss historiography has shed considerable light on the history of abuses in such placing of children under the care of institutions: Urs Hafner, *Heimkinder*, 2011. But it is a seriously under-researched topic in African history, even in Mission history, although orphans were prominent figures of marginality and in the focus of welfare institutions for centuries. John Iliffe, *African Poor*, 1987, pp. 4, 11, 22, 28, 70, 78, 204-205, 238. Betrand Taithe, *Algerian Orphans and colonial Christianty in Algeria, 1866-1939*, in French History, 2006, pp. 247-249. For a non-Catholic example of missionary politics in orphanages see Samuel S. Thomas, *Transforming the Gospel of Domesticity*, in African Studies Review, 2000.An interesting recent study in German on the colonial orphanage: Julia Hauser, *Waisen gewinnen*, in WerkstattGeschichte, 2011.

[44] *Kipatimu. Hausbesuch bei einer aussätzigen Familie,* 1926. PSKO.

[45] TNA 450/34/3 W.J.A., *note to DDSS [on folio 66-67, doc 7780]. 31.03.1934*. TNA 450/34/3 Senior Sub Assistant Surgeon Mahenge, *Leper settlement at Tabora, Mahenge. Report to the Dir of Med. Services, dated 20.03.1934*. TNA 450/34/3 W.J.A., *note to DDSS [on folio 66-67, doc 7780]. 31.03.1934*.

[46] TNA 61/129G: Claude Hollingworth Philips, *Letter MO Mahenge to ADO Kiberege. Mahenge 28.10.1933*.

Government staff in general felt it was wrong, and too expensive, to have so many people depend on food subsidies from the government, "when so many healthy people live in and about the settlement which is situated in fertile land".[47] From 1933, the Mission had already experienced the drying up of Government financial support to the Tabora leprosy work. Under these circumstances, the Medical Officer in Mahenge held that the cost of segregation in general was impracticably high, as it meant that those put into the camps were to be looked after with Government funds.

The Mission's position in terms of leprosy work was minimal at the time, and leprosy does not seem to have been a real mission priority. Schools and education had by far taken pride of place at that time and the means of the Mission were stretched. In Tabora the Mission took almost two years to erect and put in use a dispensary building paid for by the British Empire Leprosy Relief Association, BELRA. In 1933 BELRA had given £100 – equalling the annual government budget for Tabora – for building a dispensary there. But it took two years to build the stone house of 8 x 4 meters and to install the equipment in it.[48] We do not know the reasons behind the Mission's tardy action. Nor did the Government have a clear idea of Mission investment in the care of leprosy victims at the time.[49]

It shows that the Mission did not invest as much money in the medical side of leprosy care as was expected by the colonial administration. At the same time, Government subsidies were being reduced. We must assume that the declining subventions lead to substantial social repercussions in the community of Tabora settlers, with livelihoods becoming more precarious. As life was becoming harder, there was, as the Government doctor reported, "general discontentment and rather than starve, they [the people living in Tabora] look out for a chance to run away from the settlement."[50] Given governmental and missionary nervousness about segregation, the threat of running away was the leverage the inhabitants of Tabora had.[51] There is evidence that the number of inmates at Tabora dropped considerably at that moment.[52]

It is not that there was no philanthropic element in government discourse as well. When finances became scarce, the administrators had become aware of ethical questions. The Government doctor at Mahenge reminded the medical administration in Dar es Salaam, that it was the Government's duty to provide shelter and nursing care, "to maintain them [the people in Tabora] alive, for we cannot ignore our responsibility to feed them, till they die a natural

[47] TNA 450/34/3 W.J.A., *note to DDSS [on folio 66-67, doc 7780]. 31.03.1934*.
[48] TNA District Book, District Office Mahenge, No.1 / Medical: Pater Jesuald Loretz et al., *Tabora Leper Settlement*; P. Jesuald Loretz, *Ein Gruss von den Aussätzigen*, in Missionsbote der Schweizer Kapuziner in Afrika, 1934.
[49] TNA Acc.450/HE/178/16: R.R. Scott et al., *Letter to Provincial Commissioner, Eastern Prov. DSM 23.09.1935*. P. Gerard later sent a report to BELRA and photos to Dar es Salaam: TNA Acc.450/HE/178/16: Gerard Fässler, *Letter to Direct. of MS, Kwiro 07.01.1936*. TNA 61/144: R.C. Greig, *Letter acting DO to PC E.P. Mahenge 19.10.1934*.
[50] TNA 450/34/3 Senior Sub Assistant Surgeon Mahenge, *Leper settlement at Tabora, Mahenge. Report to the Dir of Med. Services, dated 20.03.1934*; TNA 450/34/3 Senior Sub Assistant Surgeon Mahenge, *Letter to Dir. of Med. Services. Mahenge 29.01.1935*; TNA Acc.450/HE/178/16: R.R. Scott et al., *Letter to Provincial Commissioner, Eastern Prov. DSM 23.09.1935*.
[51] TNA 61/129G: A. T. Culwick, *Letter to P.C.E.P. Kiberege 18.02.1933*.
[52] TNA Acc.450/HE/178/16: R.R. Scott et al., *Letter to Provincial Commissioner, Eastern Prov. DSM 23.09.1935*.

death."[53] But the general trend of policy turned in a different direction. In Ulanga, probably as in most other areas of Tanganyika, the focus turned away from care for the destitute and invalids towards those who had some prospect of being healed by medical means.

## Chemotherapy reigns supreme in policy

The aim of the medical administration was to ditch as much of the general welfare and relief costs and to concentrate on the medical. One possibility under discussion was that dressers could offer chemotherapy against leprosy in the dispensaries as a sort of peripheral out-patient service.[54] The policy was couched in medical terms, arguing that such an approach would be more effective than segregation.[55] Realistically, the weak dispensary system in Ulanga would have had problems offering such services, and providing leprosy injections would perhaps have weakened their popularity: "I have never found that Natives appreciate leprosy injections which are painful and show no immediate result."[56] It seemed better to restrict services in Tabora to those who could profit from them in a strictly medical sense.

In early 1935 the office of the Director of Medical Services informed the Sub-Assistant Surgeon in Mahenge, who was in charge of allocating government resources to the Tabora leprosy camp, that the Medical Administration was

> "not in favour [of]... unsystematic treatment of leprosy [which ] does very little good beyond temporary relief and is very expensive. The present policy is to concentrate on leprosy work in limited areas where the results of treatment can be accurately observed and recorded."[57]

The way this was formulated was a rejection of the use of medicine in the leprosy settlements in the form of a medicine that was applied less for its biomedical efficiency than for the social notions it could carry as a medicine, for the power it had to create relationships, a community, and for the way it could express consolation, care and belonging. The medical reasons were linked to a prioritization of chemotherapy:

> "I would emphasize that we cannot hope to treat with success the old cases who have lost fingers and toes [...] Hydnocerol [...] should be reserved [...] for early cases or active skin cases. Alepol may be used for others who feel that they are deriving benefit there from."[58]

In September 1935, the Director of Medical and Sanitary Services together with the District Officer visited Tabora, and met with the local medical staff and the Mission's Pro-Vicar and sisters. In a memo the Director made it clear that it was "essential that we should try to get the settlement on a better footing." A better footing clearly meant that Tabora was to be converted into a medical camp. First of all, medical supervision was to be implemented more

[53] TNA 450/34/3 Senior Sub Assistant Surgeon Mahenge, *Leper settlement at Tabora, Mahenge. Report to the Dir of Med. Services, dated 20.03.1934*.
[54] TNA 61/144: R.C. Greig, *Letter acting DO to PC E.P. Mahenge 19.10.1934*.
[55] TNA 61/129G folio 38ff: *Report [by SAS Mahenge] on Inspection of Medical Out-Stations. Mahenge and Kiberege Districts [07.01.1934]*.
[56] TNA 61/144: DST, *Memo to PC E.P. [date evt 02.11.1934]*.
[57] TNA 61/129G folio 47ff: George Maclean, *Letter Office of DMS to Sub-Assistant Surgeon Mahenge. DSM 29.01.1935*.
[58] TNA 450/34/3 R.R. Scott, *Letter Dir of Med.Services to E. Maranta, 23.09.1935*.

regularly, the Sub-Assistant Surgeon (SAS) should "pay a regular weekly visit there, probably at the same time as the Sister", and a complete list of inmates was to be compiled.[59] Medicine use was to be restricted, while, so the DMSS hoped, the power of successful chemotherapy would "attract cases likely to benefit from treatment in the early stages of the disease."[60] Compulsory segregation was definitely given up. According to the memorandum, however, children were to be removed from their family:

> "The main hope for reduction of leprosy in this Territory is by the removal of infants from contact with leprotic parents. This manifestly cannot be done by law or regulation at present but only by the influence of chiefs and leading natives and the operation of native public opinion in areas where the bulk of the people can be induced to realize the criminal folly of permitting such children to remain with their parents."[61]

It is difficult to imagine how a settlement at Tabora could ever become attractive in such conditions. On the contrary, medicalization made Tabora in the course of time a place that was declared to be in "an unsatisfactory state".[62]

## Medicalization policies bring degradation

A report from 1947 stated that the mission had relinquished control of the Tabora settlement in about 1938.[63] That date seems to be incorrect, but it does mark further changes in the set-up of Tabora which took place in the late 1930s. It is noteworthy that at the time the Church did not follow a segregation regime. In Sali, leprous and non-leprous Catholics would go to church together and share the dispensary.[64] But there was no medicine to treat them, as anti-leprosy drugs had become generally scarce in the area and the Mission was not regularly provided with them.[65] From early 1939 the mission doctor who had come to Mahenge, Alois Gabathuler, and a nurse visited the camp every month, but there had been no drugs for the leprosy camp from the British Empire's stock for a long time.[66] So Gabathuler tried to acquire a drug for testing in Tabora from Switzerland.[67] In 1939 Gabathuler was refused the extension of medical activities in the camp by his professional peers in the Medical Department who put a hard ceiling over his expectations:

> "Dr. Gabathuler is very anxious to undertake an intensive treatment of early cases but it was pointed out to him that an increase in the allocation given to Mahenge could only be, at the present time, at the expense of some other place. Leprosy is reported by the mission to be

[59] TNA Acc.450/HE/178/16: R.R. Scott et al., *Letter to Provincial Commissioner, Eastern Prov. DSM 23.09.1935*; TNA 450/34/3 R.R. Scott, *Memo of Dir of Med. Services to SAS Mahenge. Mahenge 08.09.1935*.
[60] TNA 450/34/3 R.R. Scott, *Letter Dir of Med.Services to E. Maranta, 23.09.1935*.
[61] TNA 61/144 vol II: Tanganyika Territory Direction of Medical Services, *Letter to PC E.P. DSM, 28.10.1935*.
[62] TNA 61/129H: George Maclean, *Notes on Ulanga District [recieved 18.01.1940]*.
[63] TNA 461/27/1: Tanganyika Territory District Commissioner Mahenge et al., *Annual Report Ulanga District 1947*.
[64] TNA 61/144 vol II: *Letter DO Kiberege to PC E.P. 04.08.1937*. TNA 61/144 vol II: *Letter acting PC E.P. to DMSS 13.08.1937*.
[65] TNA Acc.450/HE/178/16: Gerard Fässler, *Letter to Direct. of MS, Mahenge 05.10.1937*; TNA Acc.450/HE/178/16: Tanganyika Territory Director of Medical Services, *Letter to Fr. Gerard Fässler. DSM 12.10.1937*; TNA 450/34/3 Tanganyika Territory Medical Stores, *Letter to SAS Mahenge, 15.02.1938*.
[66] TNA 450/34/3 Gerard Fässler, *Letter to DO Mahenge. Kwiro 03.12.1939*; PAL Sch 1061.5 Mappe 3 darin "tempus 1938": Alois W. Gabathuler, *Letter to E. Maranta. Mahenge 14.12.1938*.
[67] PAL Sch 1060.3: *Letter to F.Gunter, 21.02.1939*.

> widespread in Mahenge but there is no reliable census of cases to bear this out. There appears to be no special reason why this area should be selected for intensive treatment, the one justification seems to be the presence of two doctors who are interested in the subject and who would be likely to carry out the campaign efficiently and correctly. ... It is possible that some of the cases diagnosed by untrained missionaries may, in fact, be some other disease such as pellagra or fungus infection."[68]

Clearly, the Colonial Government's policy of medicalization was a failure from the point of view of medical service provision. It had wanted that drugs were to be only used "in selected instances to those settlements in which a medical man is prepared to study and record their use in cases which hold out some hope of benefitting from them."[69] Yet such a condition had seriously limited the possibilities of chemotherapeutic intervention in a place like Ulanga, where the "medical man" was hardly ever available. But when (s)he was, the prospect of medical treatment quickly waned. Lacking drugs and medical men, the camp had come back under political administration and the District officers had applied some sort of forceful segregation policy.

> "We are also grateful that the affairs of Tabora were once more put in the hands of the District Officer. The result was soon apparent, for the numbers of the inhabitants of the colony increased by 200-300. We can have nothing but thanks for Mr. Hayne too for having brought the influence of the Boma to bear once more on concentrating the lepers, thought here is apparently no strictly legal procedure for doing so."[70]

So Tabora had again many 'old' cases (that is 'cold' cases in the medical language), on whom the small budget was spent in terms of drugs and food. Interestingly enough, the inconsistent government activity also blocked the Mission's engagement for the camp, even when, as in Gabathuler's case, a medicalized approach had been proposed. The Mission tried to wrest more money from the Government in early 1939 and then, by end of the year, the Mission refused to take full responsibility for Tabora, because the subventions were simply too meagre.[71]

Not much had changed, thus, in Tabora since the early 1930s in terms of service delivery. In 1941, the local administration was again advised on policy, which now explicitly excluded "incapables".[72] Tabora rapidly declined further. In mid-1941, the Provincial Commissioner reported after his visit, that:

> The camp is in a shocking state [...] No latrines [are available] the former ones, which according to the lepers, were constructed by them, having fallen in. [...The] mission at Kwiro apparently gives them clothes etc occasionally and injections and dressings are given by the dresser and by Gabathuler. The worst feature is the presence of a number of children, some

[68] TNA 61/129H: George Maclean, *Notes on Ulanga District [recieved 18.01.1940]*. The question whether Mahenge had particularly high numbers of leprosy cases was an old question and remained quite unresolved. In 1942 the DMSS believed in high numbers, probably informed by the mission doctor Gabathuler and the government sleeping sickness surveyor Ollendorf. But good diagnostics could also lead to high numbers diagnosed, warned the a senior medical officer at the same time. TNA 450/34/3 R.R. Scott, *Letter to SMO Dodoma. 03.11.1942*; TNA 450/439: W.A. Young, *Report of S.M.O. to Ulanga District 10.08.1942-22.08.1942 [28.08.1942]*.

[69] TNA 61/144 vol II: *Letter DMSS to PC E.P. DSM 25.08.1937*.

[70] TNA District Book, District Office Mahenge, No.1 / Medical: Pater Jesuald Loretz et al., *Tabora Leper Settlement*. 15.07.1937.

[71] TNA 61/645: Director of Med Services Tanganyika Territory et al., *Letter to Edgar Maranta. DSM, 10.02.1939*; TNA 450/34/3 E.J.W. Carlton, *Letter ADO i/c to Dir of Med Services. Mahenge 18.10.1939*; TNA 450/34/3 Gerard Fässler, *Letter to DO Mahenge. Kwiro 03.12.1939*; TNA 450/34/3 E.J.W. Carlton, *Letter ADO i/c to PC E.P. Mahenge, 04.12.1939*.

[72] TNA 450/34/3 Tanganyika Territory Director of Medical Services, *Letter to DO Mahenge. 01.04.1941*.

> of them born in the camp and others who have come to live in it in order to assist their relatives who are lepers. These children must at all costs be removed.[73]

By that time almost a decade of attempts at medicalizing Tabora had failed – and had, at least by law, disentitled many community members and destroyed the earlier welfare approaches. According to the government view, local communities used Tabora in an "immoral" way: "It is regarded as a place for the disposed and derelict relatives who are dumped on the government and the mission."[74] Certainly, livelihoods at the Tabora had not risen. In a memorandum to which Alois and Maria Gabathuler contributed, it was stated that the camp must be allowed to "die out".[75]

The memorandum suggested that an outpatient clinic could take the place of the permanent settlement and that new patients should move closer to the hospital.[76] Not least, a welfare and social medicine approach was launched:

> "Everything possible should be done to raise the general standard of feeding and personal hygiene of the WaPogoro which is appallingly low, without which the virtual eradication of the disease is, impossible."[77]

Tabora continued to exist, in a manner that was unsatisfactory to government, and in particular to the medical staff who seems to have deserted the camp by 1948. By that time, the camp was practically all Catholic, and the mission provided disabled people with salt, cloth and, sometimes, meat. Yet reciprocal help amongst the villagers was considered below what was required and the dresser was entirely single handed.[78] The Mission would eventually revive its leprosy work in the 1950s. When a new drug, Dapsone, became available, the Mission invested in a new leprosy camp in Ifakara, which still exists today as one of the largest welfare schemes in the District.[79]

## The Making of a Missionary Doctor

The dynamics of the medicalization of welfare constituted a large part of the background for the arrival of the first mission doctors in Ulanga. It is also important to look at the road the husband and wife team of the Drs. Gabathuler took into the mission organization and the hospital. The first generation of doctors working for the Capuchins in Tanzania had roots that extended beyond Switzerland – the field for recruitment was German-speaking Europe rather

[73] TNA 61/129G: *An extract from Safari Notes on PC's Tour in Province, 28.07.1941-19.08.1941*.
[74] TNA 450/34/3 *Memorandum on Tabora Leper Settlement Mahenge*.
[75] TNA 450/34/3 *Memorandum on Tabora Leper Settlement Mahenge*; TNA 450/34/3 A.G. Mackay, *Note of SMO [Dodoma?], 10.11.1942 on the treatment of leprosy by Hyndocreaol or similar....*
[76] Reply of DMSS to: TNA 450/34/3 *Memorandum on Tabora Leper Settlement Mahenge*.
[77] TNA 450/34/3 *Memorandum on Tabora Leper Settlement Mahenge*. It seems that towards the mid 1940s leprosy care become somewhat de-biomedicalized again. Leprosy policies changed in 1944 when government opted to concentrate medical treatment into large well organized settlements." (TNA 61/144: *Letter for Dir. of Med Serv to PC E.P. DSM 09.05.1944*.) Knud Balslev, *History of Leprosy in Tanzania*, 1989.
[78] TNA 450/34/3 M.T.L. Marealle, *Report of Assistant Welfare Officer to Social Welfare Organizer, DSM. Morogoro 15.11.1948*.
[79] Marcel Dreier, *Wer möchte da nicht krank sein*, 2011.

than being limited to the national boundaries of Switzerland. Heroic Mission Doctors feature often in the propaganda of mission medicine, but compared to the wealth of anecdotes, academic work on their lives is still quite scarce. The set of German-speaking Mission Doctors who were trained as members of the "Missionsärztliche Institut Würzburg" (MI) has been looked at in a dissertation by Lioba Essen.[80] The first two Catholic Swiss mission doctors trained at the Würzburg institute and were sent to non-Swiss missions in South Africa from early 1936.[81] They were followed in 1937 by Alois Gabathuler and his German wife Maria Gabathuler-Leins who went to Dar es Salaam with a contract to serve as medical doctors in the Mission of the Swiss Capuchins in East Africa.

The MI was unique as a German-language Catholic medical training institute for missionary doctors.[82] It tried to build a modern, mission-focused organization that bridged the world of Catholic organization (with its 'motherhouse' system and 'spiritual fathers'[83]) to the lay person and the academy. It offered academic training in medicine and served as a specialized intermediary between doctors and missions. The MI offered its trainees spiritual and professional guidance and placed the missionary doctors in specific missions, where they served mission Bishops under a contract, but remained members of the Würzburg Institute, too. The mission doctor students at the moment of their entry into the institute signed an oath of allegiance to the institute and promised to spend at least 10 years as mission doctors. As it would turn out, however, the Second World War in particular severed the ties of the doctors with the institute. During the war all communication was very difficult. And this meant that in the case of conflict the Gabathulers were really isolated in terms of institutional support.

The Catholic Swiss Association for Medical Missions (SKMV) was a major supporter of Alois Gabathuler. Swissness was clearly a factor here. But the Swiss Capuchin Mission in East Africa could not entirely rely on Swiss medical doctors. Gabathuler's wife, Maria Gabathuler-Leins, herself a medical doctor and a member of the MI, was born 1910 in Stuttgart in southern Germany. There she had attended a Catholic girls' school, and she claims she decided to become a mission sister very early in her life.[84] She entered the Würzburg institute in 1930.[85] The third Mission Doctor to come into the service of the Capuchins was Dr. Adelheid Schuster, another German. Originating from Breslau, Schuster had started her medical career as a missionary doctor in Uganda from 1924 to 1927, in a very early phase of Catholic mission medicine. She had

[80] Lioba Essen, *Katholische Ärztliche Mission*, 1991.
[81] Traudl Solleder, *zwei starke Frauen*, in Heilung und Heil. Mitteilungen des Missionsärztlichen Instituts Würzburg, 2009. Bertha Hardegger et al., *Mutter der Basuto*, 1987.
[82] Luitgard Maria Fleischer et al., *Missionsärztliches Institut Würzburg 1922-1997*, 1997.
[83] For an example of how the Gabathuler's understood that see: Letter dated Stuttgart 24.12.1939 in: PAL Sch 1061.5 Mappe 3: *[File:] Dr. A. Gabathuler, Korrespondenz 1931-1939*.
[84] PAL Sch 1061.5 Mappe 3 darin "tempus 1931/33": Maria J. Gabathuler, *Letter to E. Maranta. Tübingen, 08.10.1933*.
[85] MIW File Maria Leins-Gabathuler: Maria J. Gabathuler, *Lebenslauf. 27.10.1930*. PAL Sch 1061.5 Mappe 3 darin "tempus 1938": Alois W. Gabathuler, *Letter to E. Maranta, Olten or Stuttgart 30.04.1938*.

then returned to Germany but came back to work in southern Tanganyika in the Catholic mission neighbouring that of the Capuchins', from 1936.[86]

The Swiss amongst this trio, Alois Gabathuler, was born in St. Gallen in 1905, but he too did much of his schooling outside of Switzerland, in Austria (Feldkirch), and most of his medical training in Germany. Originally trained in business, Gabathuler converted to Catholicism in 1923, after his father had prevented him from entering the Protestant Basel Mission. He went to Austria where he passed his matriculation and then began his studies in medicine, while he also entered the novitiate of the Gesellschaft Herz Jesu (Jesuits?) in Feldkirch/Austria. He felt, though, that he did not have the right calling for the life of a monk, and that he was more "apt for practical than theoretical science."[87] He also was sort of isolated in the spiritual community of the novitiate. This may have been a result of his interest in medicine rather than theology, as a letter of recommendation argued.[88] However, Gabathuler was quite an egocentric and disputatious person.[89]

## Training and hiring a Catholic mission doctor for the Swiss missions

In 1928, at 23 years of age, Alois Gabathuler went to the Catholic academic Mission-congress in the Swiss Catholic spiritual centre of Einsiedeln.[90] There he connected with the SKMV and soon he joined the MI in Würzburg.[91] Just like his earlier plans with the Basel Mission, his entry into Würzburg was harshly criticized by his family.[92] This certainly did not ameliorate his financial situation in view of the rather high cost of an education in medicine. With the assistance of the Director of the MI, Gabathuler engaged in some leg-work in order to find stipends for his studies. Indeed, he received a series of stipends and contributions towards his training from a person called 'Fürst Löwenstein' from Böhmen and from the Swiss Association then under the leadership of the former Tropical medical doctor, Oskar Henggeler.[93] The SKMV

[86] Lioba Essen, *Katholische Ärztliche Mission*, 1991, pp. 61-63. Sr. Ursula Birgitta Schnell, "Missions- Benediktinerinnen von Tutzing. Hundert Jahre Priorat Ndanda, Tanzania," http://www.osb-tutzing.it/de/2007_100_Jahre_Priorat_Ndanda.pdf; Thecla Stinnesbeck, *33 Jahre Missionsärztliche Tätigkeit im Ndandagebiet in Tanganyika*, 1961. Most of the medical knowledge about Tanganyika that transfused into the Swiss mission societies and movement came from that very same place, where Dr. Thekla Stinnesbeck had worked since 1927.
[87] MIW File Alois Gabathuler: Alois W. Gabathuler, *Letter A.G. an P. Becker (Dir of MI Würzburg), Tisis [?] 26.08.1928*.
[88] Letter from the Institute Stella Matutina accompanying MIW File Alois Gabathuler: Alois W. Gabathuler, *Letter A.G. an P. Becker (Dir of MI Würzburg), Tisis [?] 26.08.1928*.
[89] MIW File Alois Gabathuler: Alois W. Gabathuler, *Letter A.G. an P. Becker (Dir of MI Würzburg), Feldkirch 18.08.1929*. At the time of his emigration to Africa a conflict with doctors at Luzern/St. Gallen over moral judgments expressed by G. erupted into a fight with lawyers involved. At first the Mission Procure in Switzerland tried to keep this secret from the Bishop "so that the beautiful beginnings are not tarnished." PAL Sch 1061.5 Mappe 3: *Letter to A.Gabathuler. Olten, 08.07.1938*; PAL Sch 1061.5 Mappe 3 darin "tempus 1938": Alois W. Gabathuler, *Letter to A. Lehner. DSM 13.07.1938*; PAL Sch 1061.5 Mappe 3 darin "tempus 1938": Alois Walter Gabathuler et al., *Letter to P. Veit 04.09.1938*. PAL Sch 1061.5 Mappe 3 darin "tempus 1938": Kuno Bürgi, *Letter to P. Veit Gadient. Winterthur 24.06.1938*.
[90] *Missionsärztlicher Verein 1926/1937,* 1938. 8-13.
[91] PAL Sch 1061.5 Mappe 3 darin "tempus 1938": Alois W. Gabathuler, *Letter to E. Maranta, Olten or Stuttgart 30.04.1938*.
[92] MIW File Alois Gabathuler: Alois W. Gabathuler, *Letter A.G. an P. Becker (Dir of MI Würzburg), St. Gallen 29.08.1928*.
[93] MIW *File Gabathuler, Alois*.

supported Gabathuler with an annual amount of 1,000 Reichsmark towards his training on the condition that he was to later work for a Swiss mission society.[94]

In 1931 Gabathuler learnt that there was little prospect of a post with the Swiss Benedictines Missionaries, who were already involved in the Ndanda hospital at that time. So Gabathuler turned to the Capuchin Mission who had no mission doctors in their service as yet.[95] He met with an unenthusiastic response from the Capuchin secretary in Luzern, Veit Gadient, who stated that schools were by far more of a priority in Dar es Salaam than the employment of a mission medical doctor."[96] It was a still a smart move on the part of Gabathuler to begin to build his networks early, as it would before too long secure him the first position to be created by a Catholic Swiss Mission for a Swiss doctor, even though he eventually did not travel to his destination before 1937.

Through all this, Gabathuler continued his studies. He worked as a nurse at the Kantonsspital in St. Gallen, went to Brussels to acquire French language skills, and to England, where he found that the English were a 'confoundedly strange people".[97] He continued at Tübingen, Cologne, Koblenz in Germany and in November 1931 he was studying medicine in Zürich, where he faced some criticism for his German connections (and manners).[98] At the same time, he unveiled his relationship with Maria Leins. The regulations of the Institute had compelled them to keep their relationship secret, and now he had to apologize to Director Becker. However Becker did not really object, and from now on the two of them could write of themselves as "we" rather than "I".[99]

In January 1932, more than five years before the arrival of the first doctors in his mission, Bishop Maranta declared his interest in appointing a Swiss doctor to the director of the Würzburg Institute. Becker recommended Gabathuler.[100] It was only in autumn 1933 that things were settled. In response Maranta accepted them both: "the issue with Dar es Saalam is settled," Gabathuler wrote, "he gladly takes me, that is us".[101]

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[94] MIW File Alois Gabathuler: Alois W. Gabathuler, *Letter A.G. an P. Becker (Dir of MI Würzburg), St. Gallen 16.10.1928*. On Maria Leins "spartan" background. PAL Sch 1061.5 Mappe 3 darin "tempus 1935": Maria J. Gabathuler, *Letter to E. Maranta. Stuttgart, 10.02.1935*.

[95] MIW File Alois Gabathuler: Alois W. Gabathuler, *Letter A.G. an P. Becker (Dir of MI Würzburg), St. Gallen, 31.08.1931*; PAL Sch 1061.5 Mappe 3 darin "tempus 1931/33": Alois W. Gabathuler, *Letter to P. Veit. St. Gallen, 13.10.1931*.

[96] MIW File Alois Gabathuler: Alois W. Gabathuler, *Letter A.G. an P. Becker (Dir of MI Würzburg), Zürich, 01.12.1931*.

[97] MIW File Alois Gabathuler: Alois W. Gabathuler, *Letter A.G. an P. Becker (Dir of MI Würzburg), Feldkirch 18.08.1929*; MIW File Alois Gabathuler: Alois W. Gabathuler, *Letter A.G. an P. Becker (Dir of MI Würzburg), Bruxelles, Collège Saint-Michel 01.04.1930*. MIW File Alois Gabathuler: Alois W. Gabathuler, *Letter A.G. an P. Becker (Dir of MI Würzburg), London, 19.08.1930*.

[98] MIW File Alois Gabathuler: Alois W. Gabathuler, *Letter A.G. an P. Becker (Dir of MI Würzburg), St. Gallen, 01.11.1931*.

[99] MIW File Alois Gabathuler: Alois W. Gabathuler, *Letter A.G. an P. Becker (Dir of MI Würzburg), St. Gallen, 26.11.1931*; MIW File Alois Gabathuler: Alois W. Gabathuler et al., *Letter A.G. an P. Becker (Dir of MI Würzburg), Stuttgart? 31.12.1931?*

[100] PAL Sch 1061.5 Mappe 3 darin "tempus 1931/33": P. Becker, *Letter to E. Maranta. Würzburg 14.09.1933*.

[101] PAL Sch 1061.5 Mappe 3 darin "tempus 1931/33": Alois W. Gabathuler, *Letter to E. Maranta. Würzburg 05.09.1933*. MIW File Alois Gabathuler: Alois W. Gabathuler, *Postcard to Becker, Luzern 21.09.1933*.

At that same time there was a major problem with Gabathuler being accepted for the Swiss state examination for medical doctors.[102] Gabathuler realized that with his Austrian Matriculation and many semesters of studying abroad he was not easily considered qualified to take the Swiss examination. Frantic attempts to control the situation followed with even the Swiss Federal Council, i.e., the State heads of Switzerland, being involved.[103] In the autumn of 1933 Germany had already gone under Hitler's dictatorial regime, and Bishop Maranta felt it was probably better to take a Swiss than a German examination.[104] Still, the conditions were such that it became clear that Maria was to complete her studies earlier than her husband-to-be.[105] The Capuchin monastery Wesemlin in Lucerne had already started to a public collection for the mission doctor.[106]

In December 1933 Alois and Maria became officially engaged.[107] The future marriage did not pose a problem for Maranta:"And if you bring a baby along," he wrote, "that will be all the more a joy to us. I must admit," Maranta continued,

> "that I have no experience whatsoever with mission doctors and their integration into the mission family, but I believe, that a mission doctor, who is not a member of the [Capuchin] congregation , and therefore cannot draw on the necessary spiritual support of it, can only successfully participate in mission work, when he has his own family as a support."[108]

This would thus firmly establish the lay identity of the future doctors and establish a difficult social division between the medical people and the other missionaries.

Concrete preparations for East Africa started in 1934 and pressure on Gabathuler rose considerably. In the meantime, a donation of CHF 20,000 from the Swiss Catholic Association for Mission Medicine towards a hospital in Kipatimu was lying idle with the Capuchins.[109] From Würzburg, Director Becker wrote: "such luck has never before dropped in anyone's lap." Becker reminded Gabathuler to work hard: "it would be an enormous disappointment and damage to the institute if it would show that you were not fit for the posting because of a lack of preparation."[110] Gabathuler also felt under pressure from the Mission. Suddenly, according to

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[102] MIW File Alois Gabathuler: Alois W. Gabathuler, *Letter A.G. an P. Becker (Dir of MI Würzburg), Bruxelles, Collège Saint-Michel 01.04.1930*.

[103] MIW File Alois Gabathuler: Alois W. Gabathuler, *Application and letters to Prof. Dr. Otto Schulthess, Präsident der eidg. Maturitätskommission, Bern. Also to: Bundesrat Dr. A. Meyer, Chef des eidg. Dept des Innern. Also to Prof. Dr. Otto Burckhardt-Socin. Zürich, 22.10.1933*; MIW File Alois Gabathuler: C. Becker, *Letter to Bundesrat Dr. A. Meyer, Chef des eidg. Dept des Innern. Würzburg, 24.10.1933*; PAL Sch 1061.5 Mappe 3 darin "tempus 1931/33": Alois W. Gabathuler, *Letter to E. Maranta. Zürich 19.11.1933*. It is not exactly clear what the problems were. Maria Kunz, also a member of the Institute was at that time doing her exams in Switzerland. Probably the Swiss were aware that the German connections could be an obstacle in the colonial territories: Friedrich Ziegler, *Zehntes Gründungsfest des Missionsärztlichen Institutes Würzburg*, in Jahrbuch des Akademischen Missionsbundes Freiburg, 1933.

[104] PAL Sch 1061.5 Mappe 3 darin "tempus 1931/33": Alois W. Gabathuler, *Letter to E. Maranta. Würzburg 26.09.1933*.

[105] MIW File Alois Gabathuler: Departement des Innern Schweiz. Eidgenossenschaft, *Letter to Alois Gabathuler. Bern, 07.12.1933*. See filed comments to this document by Gabathuler and others.

[106] PAL Sch 1061.5 Mappe 3 darin "tempus 1931/33": Alois W. Gabathuler, *Letter to E. Maranta. Zürich 19.11.1933*.

[107] MIW File Alois Gabathuler: Alois W. Gabathuler, *Letter to Becker. Zürich, 01.12.1933*. "I wish to have a medical doctor for my wife, but not one that exclusively focuses on her profession and is ruined as a woman." MIW File Alois Gabathuler: Alois W. Gabathuler, *Letter to Becker, Zürich, 21.03.1935*.

[108] MIW File Alois Gabathuler: Alois W. Gabathuler, *Letter to Becker, Zürich, 30.01.1935*.

[109] hr, *Gott zum Gruss (Editorial)*, in Missionsärztliche Caritas, 1935; MIW File Alois Gabathuler: Alois W. Gabathuler, *Letter to Becker, Zürich, 27.09.1934*.

[110] MIW File Alois Gabathuler: C. Becker, *Letter to A. Gabathuler. Würzburg 04.02.1935*.

Gabathuler, the Mission started to press for his rapid training.[111] In 1935, a feeling of urgency started to prevail. Gabathuler was told that it was imperative that they travelled by the autumn of 1937, as the British were pulling out their doctors and soon a huge area would be left without any doctor.[112]

## Medical knowledge for the Mission

Even though the doctors were not in Tanganyika yet, the close contact was a chance for the Mission to draw on the doctor's expertise. The Mission secretary availed of the knowledge of the two doctors to find cheaper drugs to send to East Africa and to get advice on a basic handbook for medicine in the tropics. On the other hand, Gabathuler was not yet ready to move. He now worked on getting specialized training in surgery with the "good Catholic" surgeon from St. Gallen who worked at the Kantonsspital there: August Lehner.[113] In the spring of 1935 Gabathuler passed his Swiss state examination and went on to do training in Gynecology in Luzern and a course in tropical medicine in Hamburg.[114] There was quite some discussion about this course, as it was a political issue to have chosen Hamburg over London.[115]

In Luzern, Gabathuler engaged in the politics of future Capuchin missionary health services for Tanganyika: Gabathuler started to argue, "from the physician's point of view", that Kwiro rather than Kipatimu should be the place of choice for the doctor. But this physician's view was not epidemiological. It was one that looked for a marketplace for his services with a large potential for a diverse set of activities.[116] Gabathuler also advised on the training for the nurse sisters from Baldegg. He suggested better hospital-based training and he pushed the importance of midwifery training, even if it went "against the religious feelings of the Senior medical doctors [in Switzerland, who were then training the nun-nurses]." After speaking to Sr. Dr. Thekla Stinnesbeck, the missionary doctor of the Benedictines, Gabathuler announced that "we are going to do it like she does: we ourselves will train locals and sisters in nursing, pharmaceutical work and midwifery."[117] This was never to be put into action.

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[111] PAL Sch 1061.5 Mappe 3 darin "tempus 1935": Alois W. Gabathuler, *Letter to E. Maranta. Luzern, 03.12.1935*; PAL Sch 1061.5 Mappe 3 darin "tempus 1935": Alois W. Gabathuler, *Letter to E. Maranta. Zürich, 03.07.1935*.
[112] MIW File Alois Gabathuler: Alois W. Gabathuler, *Letter to Becker, Zürich, 09.11.1935*.
[113] PAL Sch 1061.5 Mappe 3 darin "tempus 1934": Alois W. Gabathuler, *Letter to E. Maranta. Tübingen, 11.09.1934*. Lehner became a central figure for doctors in Ifakara. Until the 1960s it was Lehner who would offer posts for doctors recruited for work in the mission and training them for surgery.
[114] PAL Sch 1061.5 Mappe 3 darin "tempus 1938": Alois W. Gabathuler, *Letter to E. Maranta, Olten or Stuttgart 30.04.1938*.
[115] The following section is based on TNA: Acc.450/HE/178/16. Linking decision on training with future government: PAL Sch 1061.5 Mappe 3 darin "tempus 1936": Alois W. Gabathuler, *Letter to E. Maranta, Luzern, 20.08.1936*. Costs of this training also played a role. PAL Sch 1061.5 Mappe 3 darin "tempus 1936": Alois W. Gabathuler, *Letter to E. Maranta, Luzern, 07.06.1936*; PAL Sch 1061.5 Mappe 3 darin "tempus 1937": Alois W. Gabathuler, *Letter to E. Maranta, Luzern, Kantonsspital, 22.03.1937*; PAL Sch 1061.5 Mappe 3 darin "tempus 1937": Alois W. Gabathuler, *Letter to E. Maranta, Luzern, Kantonsspital, 07.07.1937*.
[116] PAL Sch 1061.5 Mappe 3 darin "tempus 1936": Alois W. Gabathuler, *Letter to E. Maranta, Luzern, 23.02.1936*.
[117] PAL Sch 1061.5 Mappe 3 darin "tempus 1936": Alois W. Gabathuler, *Letter to E. Maranta, Luzern, 19.12.1936*.

As things got ever more concrete, disagreement between the mission and Gabathuler grew. In the summer of 1937 Kwiro was the place to plan for. But there was not yet a hospital to go to. "Would there be electricity in Kwiro?" Gabathuler asked, because he would need it to build and run a hospital there.[118] The issues at stake were mostly financial: how big a wage, how much social security and financial assistance for his reintegration in Europe was Maranta going to pay?[119] The cleavage at one time was so big that Gabathuler feared that, "East Africa is going amiss".[120] P. Veit had left the post as a mission secretary and he was followed by P. Ansgar Häne. In a letter to Maranta in September 1937, Häne openly stated that he differed with the strategic decisions P. Veit had taken:

> "Personally I had been, from the very beginning, little enthusiastic about the hiring of a missionary doctor. It is because of the financial cost. But P. Veit believed at that time, that it was part of a missionary society's prestige to employ a mission doctor." [121]

Häne was ready to proceed in the direction that had been taken, but it is obvious that he looked carefully at the financial side. Things slowed down.

But with the rise of Nazism which made life difficult for Catholics in Germany, Gabathuler pushed to be taken into service sooner rather than later and, ultimately, wanted to know if they were going to be taken at all.[122] The mission was cornered. There were no other doctors available and so what would happen to the CHF 20,000 from SKVM dedicated to a new hospital, money which had already been parked in the UK?[123] In the end, Gabathuler received support from Lehner and the Bishop of his home diocese of St. Gallen in Switzerland and was able to sign a contract.[124] Alois Gabathuler had to negotiate hard for his wife to be designated in the contract (and financial agreement) "not as a nurse, but as a woman doctor".[125]

Conflict continued. Now it concerned mainly the medical equipment. Missionary finances were ranged against medical expertise. Gabathuler was said to claim medical equipment at which even other "doctors sneer that it's always the most beautiful and best he wants".[126] Gabathuler disagreed and stated that he was not even to take with him the "simplest equipment every doctor has at hand in every consultation" and that the instruments he was made to buy would be of Japanese make and cheap but not recommended from the Würzburg director and other doctors he had spoken to. [127] Soon Gabathuler became quite impatient:

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[118] PAL Sch 1061.5 Mappe 3 darin "tempus 1937": Alois W. Gabathuler, *Letter to E. Maranta, Luzern, Kantonsspital, 07.07.1937*.
[119] Häne was also critical about the salary, he suggested that G should receive 2000 and his wife 1000 £ per annum rather than 5000 between them. PAL Sch 1061.5 Mappe 1: P. Ansgar Häne, *Letter to E. Maranta. Olten 08.09.1937*.
[120] MIW File Alois Gabathuler: Alois W. Gabathuler, *Letters to MI Würzburg, 1936, 1937*, letter dated 22.11.1937.
[121] PAL Sch 1061.5 Mappe 1: P. Ansgar Häne, *Letter to E. Maranta. Olten 15.09.1937*.
[122] PAL Sch 1061.5 Mappe 1: Alois W. Gabathuler et al., *Letter to E. Maranta. Hamburg, 10.10.1937*; PAL Sch 1061.5 Mappe 3 darin "tempus 1937": Alois W. Gabathuler, *Letter to Euer Hochwürden. Hamburg 07.11.1937*.
[123] PAL Sch 1061.5 Mappe 1: P. Veit *Letter to E. Maranta. Olten 05.11.1937*.
[124] MIW File Alois Gabathuler: Alois W. Gabathuler, *Letter to MI Würzburg, St. Gallen, 22.01.1938*; PAL Sch 1061.5 Mappe 1: P. Ansgar Häne, *Letter to E. Maranta. Olten 08.09.1937*.
[125] PAL Sch 1061.5 Mappe 1: Alois W. Gabathuler, *Letter to E. Maranta. Hamburg, 12.12.1937*.
[126] PAL Sch 1061.5 Mappe 1: P. Veit Gadient, *Letter to E. Maranta. Olten 06.08.1937*.
[127] PAL Sch 1061.5 Mappe 1: Alois W. Gabathuler et al., *Letter to E. Maranta. Hamburg, 10.10.1937*.

> "it is a hopeless point to make them understand that there is no use at all in buying equipment that is of such poor quality. How do they imagine us practicing with this material, even if it was only at the start? Shall we make do with only an ear trumpet and a reflex hammer? These convent-people have no idea about things that are outside the walls of a monastery."[128]

## The doctors arrive

In early 1938 the Gabathulers were still stuck in Switzerland. He had started a temporary job and his wife took training in dental medicine in Sursee or Olten.[129] He had also started to beg donors from his German network for medical equipment and had met persons from a range of German missionary organizations.[130] The Baldegg sisters gave money to the doctors as well.[131] When the Gabathulers finally left Switzerland in the spring of 1938 they travelled with an enormous amount of material. A document in the Luzern Archives lists the contents of the 18 boxes sent from Switzerland to Dar es Salaam, insured at a value of roughly CHF 6,000 to which another four boxes, expedited directly from Germany, were added. The boxes from Switzerland contained amongst hundreds of other things, two doctors' coats, eight sets of nightclothes, twelve religious images, a crucifix, forty dresses probably for children, a set of baby scales, new and old sets of microscopes, dentists' equipment, all kinds of physician's samples that seem to have served to fill the empty spaces in the boxes. Three boxes were completely filled with books, another one with a gramophone, others with Dr Gabathuler's personal effects dowry and kitchen utensils, and cutlery.[132]

In June 1938 the Gabathulers presented themselves to the Director of Medical Services of the Tanganyika Territory. The Director checked their medical credentials and offered them internships at the Sewa Hadji Hospital in Dar es Salaam for the time they would have to spend in town before they could move to their medical practice in Mahenge.[133] Alois Gabathuler reported from the Hospital that

> "the medical director Dr. Young is friendly towards us [...] in a manner that reconciles us to some degree with the English who can be very blinkered [...] The treatment of the big masses is very instructive for our later activities. It is helpful that a number of diseases also occur in

[128] MIW File Alois Gabathuler: Alois W. Gabathuler, *Letter to Becker, Luzern, 01.09.1937*.
[129] PAL Sch 1061.5 Mappe 3 darin "tempus 1938": Maria J. Gabathuler et al., *Letter to E. Maranta, Stuttgart, 05.01.1938*.
[130] The donations he got were complicated because of the regulations on foreign currency. PAL Sch 1061.5 Mappe 3 darin "tempus 1938": Alois W. Gabathuler, *Letter to E. Maranta. St. Gallen, Meisenstrasse 4, 23.01.1938*. This donation would later create incredible problems in the conflict between the doctor and the mission. PAL Sch 1061.5 Mappe 1: Missions-Verwaltungs-Gesellschaft, *Letter to E. Maranta. Aachen, 19.08.1938*. The total value of the donation was stated as 4238.1 Reichsmark.
[131] PAL Sch 1043/Missionssekretär & Baldegg u. einzelne Schwestern: *Letter to Frau Mutter Angelica Hübscher, Baldegg. 10.05.1938*.
[132] PAL Sch 1061.5 Mappe 1: *Warensendung der schweizerischen Kapuzinermission nach DSM. Olten ab 28.04.1938...* . Letter dated 26.04.1938 in: PAL Sch 1061.5 Mappe 3: *[File:] Dr. A. Gabathuler, Korrespondenz 1931-1939*.
[133] PAL Sch 1061.5 Mappe 3 darin "tempus 1938": Alois W. Gabathuler, *Letter to Hochwürdiger Herr P. Veit. DSM 11.06.1938*; PAL Sch 1061.5 Mappe 3 darin "tempus 1938": Alois W. Gabathuler et al., *Letter to Hochwürdiger Herr P. Veit. DSM 28.06.1938*.

> high numbers, for example worm diseases [...] for the dispensers the treatment courses for each disease is posted on the walls [...and] we copy them for use in our work later."[134]

The doctors participated in some of the meetings between Government and Mission doctors, e.g., a talk by the government leprosy specialist Dr. Muir.[135] They also joined a meeting of the medical missionary committee. Not least, they also participated in social life of the white colonial administrative class.[136]

In August 1938 a long awaited safari to the interior stations finally happened. They stayed in Ifakara for two days and treated crowds of patients "with their real and imagined diseases".[137] Everywhere they passed on their trip, Gabathuler adds in his report, the Bishop was told "how happy the Blacks are that he has brought his own doctor."[138] He continued that "many have already reported for operations [...] in Ifakara we had roughly 60 consultations a day, Indians came from Kiberege and the chief from the same place came and asked for a consultation date with one of his children."[139] The doctors also installed a consultation fee:

> "We asked every patient to contribute at least 50 (R?) for medicine. I assume Sr. Arnolda received the money. We shall try to institutionalize [this fee], and the bishop agrees, and this will be a huge easing for the coffers of the mission."[140]

Maria Gabathuler also found that 'Indian' women sought her assistance as there was no other doctor to whom they were allowed to turn. She also felt that the deficient work of the Sub Assistent Surgeon helped them to find green pastures. Also because he was meant to leave the Government hospital in Mahenge in about a year: "At that point the question will become acute, who will take it over: the mission, i.e. us, or government."[141]

Back in Dar es Salaam tensions between the Bishop and his doctors resurfaced quickly. Gabathuler was bored and soon suspected the Bishop of trying to delay negotiations with the Government about a possible take-over of Mahenge hospital.[142] Gabathuler now pressed the Swiss home base for support to hasten up the negotiations, and at least some of the Capuchin Mission organization signaled some understanding for him. But the hierarchy remained clear-

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[134] PAL Sch 1061.5 Mappe 3 darin "tempus 1938": Alois W. Gabathuler et al., *Letter 02.07.1938*.
[135] TNA 455/692/: Tanganyika Territory Director of Medical Services, *Invitation to talk given by Dr. Muir, leprologist. DSM 06.06.1938*.
[136] Dsm 24.08.1938
[137] PADSM 153/3: Hieronymus Schildknecht, *Quartalbericht von Ifakara. [1938]*. Entry for 10.08.1938. The Kwiro Chronics report a visit by Gabathulers, but no medical work performed, on the same date (09.08.2011 arrival in Kwiro, 10.08.1938 Gabathulers left for Sali Mission). PADSM Box 176/Kwiro Chronik 1: *Kwiro Chronik 1902-1952*.
[138] PAL Sch 1061.5 Mappe 3 darin "tempus 1938": Alois Walter Gabathuler et al., *Letter to P. Veit 04.09.1938*.
[139] PAL Sch 1061.5 Mappe 3 darin "tempus 1938": Alois Walter Gabathuler et al., *Letter to P. Veit 04.09.1938*.
[140] PAL Sch 1061.5 Mappe 3 darin "tempus 1938": Alois Walter Gabathuler et al., *Letter to P. Veit 04.09.1938*.Gabathuler opposed the free services offered by the Mission as part of the Mahenge hospital lease agreement. Free services should only be for the destitute, for staff of the Mission- and the Hospital staff. PAL Sch 1061.5 Mappe 3 darin "tempus 1938": Alois W. Gabathuler, *Letter to E. Maranta. Mahenge 14.12.1938*. Gabathuler negotiated reduced drug prices from Hoffmann in Basel who delivered cheaper than the English firms. PAL Sch 1061.5 Mappe 3 darin "tempus 1938": Alois Walter Gabathuler et al., *Letter to P. Veit 04.09.1938*. In some mission stations a fee system was maybe in place before the arrival of the doctors *Die Schweizer Kapuziner in Afrika. Jahresbericht 1937*, 1937, p. 26.
[141] MIW File Alois Gabathuler: Maria J. Gabathuler, *Letter to MI Würzburg. Dar es Salaam 24.08.1938*.
[142] PAL Sch 1061.5 Mappe 3 darin "tempus 1938": Alois Walter Gabathuler et al., *Letter to P. Veit 04.09.1938*. PAL Sch 1061.5 Mappe 3 darin "tempus 1938": Alois W. Gabathuler, *Letter to E. Maranta. DSM 08.09.1938*.

cut: the Bishop had the final say in all matters.[143] Meanwhile, world politics turned decidedly sour: "Yesterday evening we were all considerably shaken by the latest speech of Hitler at the Nürnberg congress of the NSDAP. This was a last ultimatum not only to Czechoslovakia but to the whole world", wrote Maria Gabathuler to Maranta.[144]

## The Mission and Mahenge Hospital

Mahenge hospital had been started during the German colonial period. From the beginning of the British mandate at times a Medical Officer was stationed at the hospital and at other times an 'Indian' Sub-Assistant Surgeon (SAS) was at the head of the hospital.[145] About ten people worked in the hospital in the late 1920s.[146]

The Director of Medical Services (DMSS) reported in 1932 that Mahenge hospital „is well built with ample accommodation for the needs of the district." The major problem was the location on the Mahenge plateau and that for this reason the hospital was far removed from the settlements, communication and transport systems in the Kilombero and Ruaha River plains.[147] In terms of its administrative and economic importance, Mahenge at the time was declining. Apart from the economic changes that Lorne Larson has described as the rise of the 'Ifakara System'[148], the financial tightrope on state spending in the 1930s must have weakened a primarily administrative station as Mahenge was. When in the second half of the 1930s medical services based in Mahenge underwent financial cuts there remained at best one SAS stationed at the hospital and, sometimes, even this lone figure with an intermediate level of training was reportedly absent.[149]

Once Gabathuler worked in the small hospital of the Mission school in Mahenge/Kwiro he immediately set his sights on the hospital. According to him, "it really didn't need a doctor for the medical work he did outside the hospital. But in Mahenge hospital there were coronary diseases, difficult cases of contagious disease, and better drugs with which we could work more efficiently than the SAS."[150] To place the Mission's doctors in that hospital would be a big step for

[143] See correspondence in PAL Sch 1061.5 Mappe 3: *[File:] Dr. A. Gabathuler, Korrespondenz 1931-1939*.
[144] PAL Sch 1061.5 Mappe 3 darin "tempus 1938": Maria J. Gabathuler, *Letter to E. Maranta. DSM, 13.09.1938*.
[145] TNA 450/34/3 District Office Mahenge, *Letter to Principal MO. Mahenge 07.10.1920*; TNA 450/34/3 *Letter from Medical Office, Mahenge to Dir of Med. Services. 06.04.1928*; TNA 450/34/3 James Septimus Armstrong, *Letter MO Mahenge to Dir Med. Services. Mahenge 24.05.1929*. On the SAS Mr. Purundare see TNA Acc.450/HE/178/16: Gerard Fässler, *Letter to Direct. of MS, Kwiro 17.09.1935*.
[146] *Kwiro: Die beiden indischen Doctores von Mahenge mit ihrem Spitalpersonal,* 1928. PSKO.
[147] TNA 61/231: A.H. Owen, *Report DMSS to Chief Sec. on visit to Mahenge, Kiberege and Kilosa. December 1932 [stamped PC E.P. 06.12.1932]*.
[148] Lorne Larson, *History of Mahenge*, 1976.
[149] TNA 450/34/3 Senior Sub Assistant Surgeon Mahenge, *Letter to Dir. of Med. Services. Mahenge 29.01.1935*; TNA 461/28/9: *[Monthly Report for November 1937. Mahenge Division - Ulanga District (manuscript only, n.d.)*; TNA 461/28/9: S.R. Tubbs, *Monthly Report for October 1937. Mahenge Division - Ulanga District (07.11.1937)*. TNA 461/28/9: *[Monthly Report for November 1937. Mahenge Division - Ulanga District (manuscript only, n.d.)*.
[150] PAL Sch 1061.5 Mappe 3 darin "tempus 1939": Alois W. Gabathuler, *Letter to P. Veit. Mahenge, 14.01.1939*. The hospital of the school had 20 beds in one room. The most pressing medical problems were Malaria, Pneumonia and Hookworm: *Die Schweizer Kapuziner in Afrika. Jahresbericht 1940*, 1940, p. 17.

the Mission, albeit not one that was taken easily. In May 1938 Bishop Maranta had already proposed to the Director of Medical and Social Services (DMSS) of Tanganyika Territory to station the Mission doctors who were about to arrive at his Mission at Kwiro/Mahenge. He had already secured the support of the DO/DC in Mahenge.[151]

## Discussing a Catholic take-over

In September of the same year, the question of the lease of the hospital in Mahenge to the Mission was discussed between the Director of Medical Services (DMSS) and the Chief Secretary in Dar es Salaam. The DMSS believed that the Gabathulers would take on all the duties of a Government Medical Officer and that Ulanga – meriting "more generous treatment than it has yet received" – would furthermore profit if the Sub-Assistant Surgeon could be stationed in another section of the District.[152] The negotiations about a take-over of the government hospital by the Mission provoked a debate about mixing too much Catholicism into the secular medical services. This debate slowed down the Gabathulers' practice once again. While the sources allow us to understand that the DMSS discussed the lease of the hospital to the mission in a generally supportive manner at Dar es Salaam, Gabathuler, sitting in Mahenge, had soon given up hope of geting into the Government hospital. Maranta had the time at his disposal to achieve a better result in the negotiations.[153] Maranta had his ways and he also had experience in dealing with the colonial administration; he did not want the doctor to be involved in the negotations. Maranta advised Gabathuler to use his powerful critical capacity in medicine, leaving everything else in the hands of the Bishop. "Pushing and shoving" would not produce results with the "careful British", Maranta knew.[154] Especially when, as Maranta explained more than a decade later, "two elements will always speak against us: that we are Catholic and not English."[155]

In Mahenge, Gabathuler was told by the District Officer that it had been a mistake for Maranta to have discussed things in Dar es Salaam with the medical department, because he as the political officer in Mahenge would be the one to take the decision.[156] Intra-administrative conflicts thus mixed with real local politics.

[151] TNA 461/28/9: R.H.R. Hayne, *Monthly Report for May 1938. Mahenge Division - Ulanga District (06.06.1938)*.
[152] TNA 61/645: Director of Med Services Tanganyika Territory, *Letter to PC Eastern Prov. DSM, 20.09.1938*.
[153] It is not possible to understand the detailed politics of this. It is possible that Maranta used the hospital question to bargain harder with Government than Gabathuler realized. Certainly in 1935 Maranta had negotiated about cooperation in Tabora Leprosy camp with Government while announcing his future investment in Medical doctors: TNA Acc.450/HE/178/16: Edgar Maranta, *Letter to Direct. of MS, Ifakara, 29.10.1935*.
[154] PAL Sch 1061.5 Mappe 1: Edgar Maranta, *Letter to A. Gabathuler. DSM 23.10.1939*.
[155] PAL Sch 1061.2: Edgar Maranta, *Letter to Dr. Heinz Wolfram. DSM 28.06.1955*.
[156] PAL Sch 1061.5 Mappe 1: Alois W. Gabathuler, *Letter to E. Maranta. Kwiro, 29.09.1938*.

The District Officer in Mahenge was afraid that the government hospital would be turned into a proselytizing institution: "He could not accept that Africans would be taken by surprise with baptism shortly before dying…", Gabathuler reported.[157] And he concluded from that:

> "If such [ruling out of Catholic presence in the hospital] will be the preconditions for our take-over of the hospital, it will be better we would drop the suggestion and build our own hospital from the beginning."[158]

The stage was set for a conflict on the religious character of the hospital. Gabathuler saw it as a sort of an occupational ban for him as a mission doctor. He feared that the DO "would never accept a nun to cross the sill of the hospital, or that crucifixes and other Christian emblems could be displayed in the wards." And he believed that this District Officer felt that Islam was the true religion for Africans and that Catholicism would lower the civilization of Africans.[159]

The colonial administrators' views betray their worries about handing over what they considered a powerful state institution into the hands of the Catholic mission. Additionally, they were not convinced that the Capuchin Mission could be trusted to deliver equal services to all Ulangans. All local administrators, including the Provincial Commissioner and the DMSS in Dar es Salaam were cautious about the Catholic element. They did not easily come to an internal agreement on how much weight their suspicions should be given in their final decision. The Mahenge DO suggested they limit the lease to two years with a possibility of extension.[160] The Provincial Commissioner and the officer in Kiberege reinforced these misgivings, and wanted the contract "to ensure that the Hospital is used solely as a Hospital and not as an adjunct to enlarge the scope of the Mission."[161]

But the administrators also agreed that Government needed to do something about the shortage in medical services and "to have three qualified persons falling over each other in a place like Mahenge hardly serves to this end."[162] The issue of the Catholic character of the hospital was therefore to be weighed against the advantages the take-over brought in terms of health service provision in Ulanga. For the benefit of the DMSS's office, the case for the lease was made with the argument for "a more equitable distribution of medical facilities throughout the District", which was first and foremost a question of staff availability.[163] It was also an enhancement that did not cost the Government much – in fact, their contribution was so meagre that the Mission doctor felt it should be unacceptable to the Mission.[164] But when it came to funding, the Catholic character of the Mission also provided a reason to exonerate the Pogoro

[157] The DO in question, Haynes, was not considered by Gabathuler to be a friend of the mission. PAL Sch 1061.5 Mappe 3 darin "tempus 1938": Alois W. Gabathuler, *Letter to P. Veit, Mahenge 13.12.1938*.
[158] PAL Sch 1061.5 Mappe 1: Alois W. Gabathuler, *Letter to E. Maranta. Kwiro, 29.09.1938*.
[159] PAL Sch 1061.5 Mappe 1: Alois W. Gabathuler, *Letter to E. Maranta. Kwiro, 29.09.1938*.
[160] TNA 61/645: District Office Mahenge, *Letter to PC Eastern Prov. Mahenge 03.10.1938*.
[161] TNA 61/645: Provincial Commissioner Eastern Prov., *Letter to Dir. Med. Services. 02.11.1938*. TNA 61/645: District Office Mahenge et al., *Letter to PC Eastern Prov. Kiberege 15.10.1938*.
[162] TNA 61/645: District Office Mahenge et al., *Letter to PC Eastern Prov. Kiberege 15.10.1938*.
[163] TNA 26367/Mahenge Hospital: R.D.H. Arundell, *Letter Director of Medical Services, DSM 07.12.1938 to Chief Secretary DSM*. It was impossible to establish on what grounds the 'equity' argument by the DMSS' office rested.
[164] PAL Sch 1061.5 Mappe 3 darin "tempus 1938": Alois W. Gabathuler, *Letter to E. Maranta. Mahenge 14.12.1938*.

Native Treasury from contributing to the upkeep or extension of medical services at Mahenge: "I do not think it advisable that the Pogoro Native Treasury, presumably a non-sectarian body, should be asked to contribute to the services of a rigidly-minded religious community", the local administration reasoned.[165]

The lease agreement would enable the Government to place the Sub-Assistant Surgeon at another location. Notwithstanding the petitions from Ifakara for better Government health services, it would not be Ifakara or any other place in the Kilombero valley which received the services of the SAS. He seems to have been transferred out of the area altogether.[166] So the Kilombero valley went without better services until the coming of Sleeping Sickness concentrations, while in Mahenge pragmatism prevailed and government officials dropped the quibble about Catholicism. The administration accepted Maranta's promise that "Mission policy and practice will continue to remain what it has been hitherto, namely the willing acceptance and impartial treatment of all patients irrespective of race and creed". The PC EP saw the small risk of discrimination outweighed by the savings made and "the DO states that leading Mohammedans to whom he has spoken are content that the change should be made". After these negotiations the stumbling block for Gabathuler, the one prohibiting 'religious propaganda', fell.

For a period of at least five years the hospital was therefore to be run by the Mission on a lease and for a nominal rent. A small grant from the Government would help to pay for drugs. Government staff would remain on the Government payroll, while the hospital was to continue to offer free treatment to all Government employees and prisoners. The mission would receive an additional lot of two acres to build extensions to the hospital. It would also be given all the existing equipment, but not the instruments, as a gift. Additionally, the Mission was offered drugs and dressings of a standard type from departmental stores DSM or cash in lieu if Mission prefers.[167]

## Negotiating missionary priorities

The way the local administrators spoke of the Mission as a sectarian group gives us a hint of the realities of Catholic life within the isolated missionary community during wartime. The situation quickly turned into a breeding ground rife with fierce conflict and factious in-fighting that would take a particularly ugly character around the practice of medical mission work in Kwiro. A series of themes runs across these conflicts, surfacing now and again.

[165] TNA 61/645: District Office Mahenge et al., *Letter to PC Eastern Prov. Kiberege 15.10.1938*; TNA 61/645: District Office Mahenge, *Letter to PC Eastern Prov. Mahenge 03.10.1938*.
[166] TNA 61/645: District Office Mahenge, *Letter to PC Eastern Prov. Mahenge 03.10.1938*. See note by R.S. 21.01.1941 on TNA 450/653: A. T. Culwick, *Letter to Dir of MS. Kiberege 27.01.1941*; TNA 61/231H: R.R. Scott, *Letter Dir. of Med.Services to Chief Sec.: "Hospital Ifakara". DSM, 29.01.1941*; TNA 61/645: District Office Mahenge et al., *Letter to PC Eastern Prov. Kiberege 15.10.1938*; TNA 61/645: Provincial Commissioner Eastern Prov., *Letter to Dir. Med. Services. 02.11.1938*; TNA 61/645: District Office Mahenge, *Letter to PC Eastern Prov. Mahenge 03.10.1938*.
[167] TNA 26367/Mahenge Hospital: Tanganyika Secretariat DSM, *Note of a meeting regarding the proposal to lease the Mahenge Hospital to the Roman Catholic Capuchin Mission, 29.12.1938*.

For one thing, the variance about the religious importance of medical work soon extended into interaction within the Mission and poisoned relationships between Gabathuler and Maranta and his closer allies.[168]

I have argued above that the Mission Doctor engaged with the medical policies of the Mission. Now this began to touch upon the question of missionary politics in terms of relations with secular Government and on the mission element in medicine. The issue was linked with a question of perspective: from the point of view of his professional politics Gabathuler strongly defended the role of the doctor as a missionary. However the question of relations with the Government touched on the issue of the role of the Catholic Church and Catholic power within state and society in a much more general way. Gabathuler, a newcomer still infused with the ideology of the 'mission to the heathen', missed the character the work of the Capuchin Mission had assumed. This work was about the installation of a powerful Catholicism, more than about quick conversions and the performance of a missionary habitus.[169] This can be seen clearly from the conflict that erupted with the head of the Kwiro mission and rector of the school, P. Gerard Fässler.

Alois Gabathuler started his medical work in Mahenge in the small hospital in the Mission School which fell under the Rector, P. Gerard.[170] But Gabathuler felt he had take a stand against the Rector wanting the exclusive use of his services:

> "After all, we do not understand our profession as a service to missionary staff and those on the mission station only. The statute of our Institute says our mission is to convert. The Rector and Superior cannot be our boss, and we felt we can insist on our special mission. But this led to a series of unpleasant clashes. We sometimes felt utterly superfluous."[171]

Gabathuler was prepared to work for the school, but not exclusively for them. The Rector would decide their night watches, Gabathuler complained, and he had sent former pupils to work as dressers, and then fired them again. At the start, the Rector had even decided when a pupil had been healed and fit for release from the hospital.[172]

P. Gerard who was the head of the Mission in Kwiro clearly gave priority to the prosperity of that important centre of Catholic spirituality and learning over medical services to the mass of the population. He must have been convinced that the health of the missionary and the members of the future African Catholic elite were to be given priority over the public performance of the healing power of biomedicine, even if it was done by a Catholic doctor in the employ of the Mission. P. Gerard had also, more plainly, a predilection for his own, already established field of work, which was education, over the newcomer, medicine. Education too was partially based on cooperation with the Government.

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[168] PAL Sch 1061.5 Mappe 3 darin "tempus 1938": Alois W. Gabathuler, *Letter to E. Maranta. Mahenge 14.12.1938*.
[169] Maia Green, *Priest, Witches and Power*, 2003.
[170] Alois W. Gabathuler, *Bericht Dr. Gabathuler-Leins, Mahenge, Ost-Afrika*, in Missionsärztliche Caritas, 1940.
[171] MIW File Alois Gabathuler: Maria J. Gabathuler, *Letter to MI Würzburg. Dar es Salaam 29.01.1939*.
[172] PAL Sch 1061.5 Mappe 1: Alois W. Gabathuler, *Letter to E. Maranta.Mahenge, 24.01.1939*.

To a large degree however, the conflict was not only one of Mission and church policies and priorities. Gabathuler also realized the potential of a hospital for providing health services in Ulanga. His vision of a new hospital set him in opposition to the politics of Maranta. The latter, having to juggle many tasks, could only afford to make a limited investment in health care. While the take-over of the Government hospital was a good solution for a series of problems, it was certainly a very different approach from the large-scale investment the same Bishop was to undertake in Ifakara 15 years later, when he built a large, new and modern hospital. But in Gabathuler's eyes, it was probably difficult to accept that he was to retain an old building. Certainly, he felt that the contract was all the more unfavourable for the Mission as he saw the existing building as nothing but a "rotten, vermiculated old pile". He had already found a piece of land on which he hoped to build a new hospital with the money from SKMV. In his own Mission Hospital, they were to be able to charge fees and would not have to accept patients whom he regarded as "working against the mission". Gabathuler considered, that "this was much more desirable than working with the 'heathen, freemason' English government".[173] It was an unrealistic plan, however. A large part of the donations dedicated to the hospital had been by that time spent already. If a hospital was to be built from scratch, there would be no money left for its equipment after the building had been erected.[174]

When things finally looked all settled at the beginning of 1939, there was yet another a small drama. The hospital lease was held up by [the Department of Lands] since the exact dimensions of the hospital grounds had not been established. Adding to this, processing the land titles took a long time. From 14 April 1939 until 31October 1939, the lease could not be signed because of legal and administrative complications that we need not go into here.[175] This rekindled the flames of conflict. In January 1939, at the height of their frustration with the slow progress towards the establishment of a true Mission Hospital in Mahenge, the Gabathulers

[173] PAL Sch 1061.5 Mappe 3 darin "tempus 1938": Alois W. Gabathuler, *Letter to E. Maranta. Mahenge 14.12.1938*. Gabathuler repeated these arguments after the agreement with Government was realized. PAL Sch 1061.5 Mappe 3 darin "tempus 1939": Alois W. Gabathuler, *Letter to P. Veit. Mahenge, 14.01.1939*. Gabathuler had even Br. Konrad draw plans for the hospital. PAL Sch 1061.5 Mappe 3 darin "tempus 1939": Alois W. Gabathuler, *Letter to E. Maranta. Mahenge 10.01.1939*. That fees for in-patients were an unsolved point: PAL Sch 1061.5 Mappe 1: Alois W. Gabathuler, *Letter to E. Maranta.Mahenge, 24.01.1939*.

[174] PAL Sch 1061.5 Mappe 1: Edgar Maranta, *Letter to A. Gabathuler. DSM 23.10.1939*. "The Bishop is the only person who can report about the use of the CHF 20'000". At that time the Swiss Procura had spent a total of CHF 36'294 on Gabathulers account. PAL Sch 1061.5 Mappe 4 darin "tempus 1941": P. Guido Käppeli, *Letter Olten, 01.04.1941*.

[175] TNA 26367/Mahenge Hospital: Tanganyika Secretariat DSM, *Notes Re: Hospital Mahenge, lease of land, employment Gabathulers, Re-building of Mahenge Hospital*. PAL Sch 1061.5 Mappe 3 darin "tempus 1939": Alois W. Gabathuler, *Letter to E. Maranta. Mahenge 14.05.1939*; PAL Sch 1061.5 Mappe 3 darin "tempus 1939": Edgar Maranta, *Letter to A.Gabathuler. 30.05.1939*; TNA 26367: *Note 13.07.1939*; TNA 61/645: District Office Mahenge et al., *Letter to Dir. of Med. Services. Mahenge 19.08.1939 re: Handing over Native Hospital Mahenge to Mission*; TNA 26367: Dept. of Lands and Mines Tanganyika Territory et al., *Letter No 21362/10 Dept. of Lands and Mines, Land Officer to Registered Trustees of the Roman Catholic Vicariate of DSM, re: Mahenge Hospital, DSM. DSM 19.09.1939*; TNA 26367: *Letter No 21362/12 Dept. of Lands and Mines, Land Officer to Registered Trustees of the Roman Catholic Vicariate of DSM, re: Mahenge Hospital, DSM. DSM 24.10.1939*. For the equipment left as present or on loan see TNA 26367: W.A. Young, *Letter for Dir. of Medical Services to Provincial Commissioner Eastern Province, DSM. DSM 31.03.1939*. TNA 61/231G: Director of Med Services Tanganyika Territory, *Letter to E. Maranta. 26.07.1939*. For a list of the hospital's buildings and wards see TNA 26367: Dept. of Lands and Mines Tanganyika Territory et al., *Letter No 21362/10 Dept. of Lands and Mines, Land Officer to Registered Trustees of the Roman Catholic Vicariate of DSM, re: Mahenge Hospital, DSM. DSM 19.09.1939*. TNA 61/645: *Regd. Plan No. 5479 [Plan hospital and surroundings on the leasehold]*.

wrote a letter to the director of the Würzburg Institute. The letter, not intended for publication by the Gabathulers, ended up as a report in the Würzburg Yearbook.[176] The Gabathulers said they had been hindered while trying to accomplish anything at all. The Mission had been not at all prepared their arrival: the dispensary was badly equipped, the rooms dark, the nurse ignorant of medical work. Even the African patients did not care to trust their outstanding competence in the modern medicine sector in Ulanga. When the Mission in Switzerland and Maranta in Dar es Salaam took notice of the letter, in October of the same year, they thought it was "mean", and "ungrateful" and Maranta immediately took the opportunity to pick his fight with "the Herr Missiondoktor who knows the trade of criticizing only too well".[177] Maranta therefore promptly reproached Gabathuler that he would destroy rather than assist the mission: "Haven't you come over to help us, not to smash us entirely?" Maranta reminded the doctor.[178] Maranta was not ready to accept that in Gabathuler's report the Mission appeared like an "enemy of the mission medical idea", especially since the report was even reviewed in the *Osservatore Romano*.[179] Gabathuler at first defended his views, and complained that the Bishop wanted to use the unlucky story of the publication of his letter to get rid of him.[180] Soon, the Gabathulers were so frustrated and upset with his situation that they wanted to return to Europe. The Mission's procurator in Luzern or Olten, Guido Käppeli, and maybe some other missionaries persuaded them to stay on – and the War did the rest in keeping them there.[181] The Gabathulers apologized to the Bishop and Maranta duly stated his firm resolve to retain the Gabathulers, "although," or so the Gabathulers now learnt, "he had been warned about us, and indeed the whole affair of missionary doctors".[182]

## The mission takes centre stage in health care provision

In the meantime the Gabathulers had waited to have the hospital handed over. Eventually, Alois and Maria Gabathuler started practice in the hospital from July alongside the Government SAS. On 18 August 1939 the hospital was handed over to them. While Alois Gabathuler took charge of the operating theatre and offered consultations at the Mission schools,

[176] PAL Sch 1061.5 Mappe 1: Alois W. Gabathuler, *Copy of letter of 29.01.1939 [printed in Katholische Missionsärztliche Fürsorge, Jahresbericht 1939]*. The copy in Würzburg allows to see the edited sections, and also that this letter was mainly written by Maria Gabathuler: MIW File Alois Gabathuler: Maria J. Gabathuler, *Letter to MI Würzburg. Dar es Salaam 29.01.1939*.

[177] PAL Sch 1061.5 Mappe 1: Edgar Maranta, *Letter to A. Gabathuler. DSM 23.10.1939*; PAL Sch 1061.5 Mappe 1: P. Wolfrid *Letter to E. Maranta. Luzern, 27.11.1939*.

[178] PAL Sch 1061.5 Mappe 1: Edgar Maranta, *Letter to A. Gabathuler. DSM 23.10.1939*. Note the agricultural expression of destroying a plant viciously.

[179] PAL Sch 1061.5 Mappe 1: Edgar Maranta, *Letter to A. Gabathuler. DSM 23.10.1939*. On the Osservatore Romano: PAL Sch 1061.5 Mappe 1: Edgar Maranta, *Letter to A. Gabathuler. DSM 01.11.1939*.

[180] PAL Sch 1061.5 Mappe 3 darin "tempus 1939": Alois W. Gabathuler, *Letter to P. Guido. Mahenge 11.11.1939*. See also his letter in the same file dated 09.11.1939.

[181] MIW File Maria Leins-Gabathuler: F. Gabathuler, *Letter to MI Würzburg, Stuttgart 12.12.1939*; PAL Sch 1061.5 Mappe 4 darin "tempus 1942": Alois W. Gabathuler, *Letter to G. Käppeli. Mahenge 25.10.1942*.

[182] PAL Sch 1061.5 Mappe 3 darin "tempus 1939": Alois W. Gabathuler, *Letter to P. Guido. Mahenge 17.12.1939*; PAL Sch 1061.5 Mappe 1: Alois W. Gabathuler, *Letter to Direktor of Missionsärztliches Institut Würzburg. Mahenge, 17.12.1939*.

his wife ran the polyclinic and, for some time, did a good amount of dental work.[183] By the end of the year they had 1,800 patients registered and, depending on the weather, they saw up to 100 out-patients per day and had to prepare new rooms for the rising number of in-patients.[184] As the head of the Mission in Kwiro, it fell to P. Gerard to help with food as the Government had not left any supplies.[185] From mid 1940-41, the Hospital registered 331 operations, 10,700 sick-days of 503 in-patients and 3,507 outpatients who had come for 21.430 consultations.[186]

Apart from what was probably a rise of medical service availability and quality, with Mahenge hospital being under Mission management there were changes in the organization of health services in Ulanga. Sanitation services in Ulanga had to be reorganized. Since qualified Government medical staff was no longer available, the Assistant District Officer was put in charge. Naturally, the medical tasks slipped towards the Mission Doctor.[187] From February 1939, the dressers who were sent for training to Mahenge were now being trained by Gabathuler. [188]But this did not suffice to assure quality at the peripheral dispensaries. Two years later, the Provincial Commissioner reported that

> "the tribal dressing stations in Ulanga are suffering badly from lack of inspection by a medical officer and it is very desirable that Gabathuler should inspect them periodically. This can only be done if the Director of Medical Services will make him a grant to cover the petrol used."[189]

The need for a qualified member of the medical staff, with a job profile that included the administrative duties that would be performed by a state employee, becomes obvious. What we witness in this situation is the process of the taking over a range of crucial task in the district health system by Catholic mission medical services. Dispensary supervision was but one example of many medical functions slowly coming under the control of the Catholic doctor.

## Catholicize (proto-)professions

The take-over under the leadership of a mission doctor also allowed the subordinate staff at the hospital and in mission services to be professionalized and catholicized. The presence of the two missionary doctors brought substantial change for the labour at the hospital. Much of the staff at the hospital was, within a period of about a year, replaced. Even before the handing

[183] Alois W. Gabathuler, *Bericht Dr. Gabathuler-Leins, Mahenge, Ost-Afrika*, in Missionsärztliche Caritas, 1940; PAL Sch 1061.5 Mappe 4 darin "tempus 1940": Alois W. Gabathuler et al., *Bericht Dr. Gabathuler-Leins, Mahenge Ostafrika*; PAL Sch 1061.5 Mappe 3 darin "tempus 1939": Alois W. Gabathuler, *Letter to P. Veit. Mahenge, 14.01.1939*; PAL Sch 1061.5 Mappe 1: Alois W. Gabathuler, *Letter to E. Maranta. Mahenge, 21.07.1940*.
[184] PAL Sch 1061.5 Mappe 3 darin "tempus 1939": Alois W. Gabathuler, *Letter to E. Maranta. Mahenge 22.08.1939*; Alois W. Gabathuler, *Bericht Dr. Gabathuler-Leins, Mahenge, Ost-Afrika*, in Missionsärztliche Caritas, 1940.
[185] PAL Sch 1061.5 Mappe 4 darin "tempus 1940": Alois W. Gabathuler et al., *Bericht Dr. Gabathuler-Leins, Mahenge Ostafrika*.
[186] PAL Sch 1061.5 Mappe 4 darin "tempus 1941": *[Statistic] Ärztliche Tätigkeit im Spital Mahenge vom 01.07.1940 bis 30.06.1941*.
[187] TNA 61/14D: R.R. Scott, *Letter DMSS to PC E.P. DSM 04.01.1939*. (The decision was approved by the PC on 10.01.1939. TNA 26367: W.A. Young, *Letter for Dir. of Medical Services to Provincial Commissioner Eastern Province, DSM. DSM 31.03.1939*.
[188] PAL Sch 1061.5 Mappe 3 darin "tempus 1939": Alois W. Gabathuler, *Letter to E. Maranta. Mahenge 07.02.1939*.
[189] TNA 61/129G: *An extract from Safari Notes on PC's Tour in Province, 28.07.1941-19.08.1941*.

over, Maranta had made it quite clear to the Government that the mission would bring in nuns as additional nursing staff.[190] Clearly, Gabathuler wanted an almost total change in the staff, and his reasons were to a large degree 'medical'. After a first glance inside the hospital, and even before the official take-over, Gabathuler complained that:

> "our orders are simply not executed at all, neither by the SAS nor by the dressers. The first entirely blames the latter for this, and really he seems to have no authority over them at all. As I see it already today, the running of the hospital will later be such as that I can only entrust black dressers with work they can do without injuring neither patients nor the hospital's smooth running."[191]

Gabathuler wanted, it seems, as many well-trained members of staff as possible. But Maranta felt he needed to caution Gabathuler about his expectations:

> "I certainly understand that the personnel at the hospital won't live up to your standards in every single respect – that is a common thing here in Africa in other domains as well [...]. But since Government has been able to run the hospital in Mahenge with this staff for those many years I see no reason why you as a capable director shouldn't perform, with the help of two nurses, at least as good. That is absolutely sufficient for the moment." [192]

Many of the hospital staff had worked for a long time in the colonial medical service and at Mahenge hospital. Not only were they (probably) among the small group of Africans in Ulanga in the ambit of formal, bureaucratically regulated labour relations, they had also learned to work on entirely on their own and probably according to their own styles in their job. In general, Government employment offered some specific 'advantages'. Regular cash income was one. Free access to hospital services was another. When Gabathuler discussed the risks in having to offer - under the terms of the Government lease – free medical treatment to Government employees, he noted that these employees would expect all their relatives to be included under this regulation. Even those who had temporary worked for the Government roads would claim such free services. Against such a perception of generalized entitlement towards the colonial state, labour relations were conceived of as a largely personalized service by the colonial administration. It seemed necessary that the Government staff who were to work under Gabathulers but who were paid through the District Office, received their salary literally out of the hand of Gabathuler. The DMSS himself initiated what became a sort of a paycheck-voucher system, based on the argument that "it is in my experience not satisfactory for the African staff to receive their money from a person other than the one under whom they are actually serving."[193]

Some time into the procedure of aligning property rights around the hospital between Government and Mission it was found that some of the employees had built private houses with their own money on the hospital ground. It was argued that they had built these houses "at the

[190] TNA 26367/Mahenge Hospital: R.D.H. Arundell, *Letter Director of Medical Services, DSM 07.12.1938 to Chief Secretary DSM*.
[191] PAL Sch 1061.5 Mappe 3 darin "tempus 1939": Alois W. Gabathuler, *Letter to E. Maranta. Mahenge 14.05.1939*.
[192] PAL Sch 1061.5 Mappe 3 darin "tempus 1939": Edgar Maranta, *Letter to A.Gabathuler. 30.05.1939*.
[193] TNA 61/645: Director of Med Services Tanganyika Territory et al., *Letter to PC Eastern Prov. DSM, 19.01.1939*; TNA 61/231G: Director of Med Services Tanganyika Territory, *Letter to E. Maranta. 26.07.1939*.

instructions of various SASs" and that therefore they were entitled to compensation.[194] This episode shows that it was normal and expected that orderlies lived close to the hospital. But it also shows that this staff drew entitlements because they were closely associated with the hospital. The Dressers Simon Longwe and certainly Robert Munthali had worked for a long time at the Government hospital, they had seen many a Medical Officer and SAS come and go and sometimes had worked in the absence of a medical superior. It is worthwhile to imagine the role they played as health care specialists not only during these times, but also when they were residing in the hospital grounds.

Maybe this was a reason for Gabathuler to quickly replace Munthali and the dresser Matthias.[195] 'A new broom sweeps clean' seems to have been Gabathuler's approach: "Although Dr. Gabathuler has no definite complaint against [Munthali] he wishes to replace him by a younger man whom he can train. Robert has become somewhat set in this way and is now difficult to teach."[196] Furthermore, Gabathuler got rid of dresser Mathias Paulo, and the Ayah bint Fundi. Gabathuler instead brought in two dressers who had been trained since 1934 in the Benedictine Mission hospital in Ndanda by Dr. Thekla Stinnesbeck, Faustin Mhitu bin Xavia und Filipi Akapa bin Killian. He would have to pay them roughly half the salary that had been spent for the long-time orderlies in Mahenge, which still meant a rise in pay to the two new arrivals.[197] The new female staff came most likely from the Capuchin and Baldegg trained community in Dar es Salaam: "The Ayah," the ADO reported, "will be replaced by a Goan girl who has worked at the Sewa Hadji hospital and has now been employed by the Mission." Gabathuler also planned to hire additional staff, for example a third man to carry water.[198]

Thus, if discrimination on the grounds of religion was excluded by the loan regulations, it certainly did not prevent the mission from making exclusive choices in terms of staff. There might have been a strain of bitterness in the colonial administration about the way the Mission arranged labour relations, as the Mission offered better pay for that staff out of their own resources and according to their own regulations.[199]

The two new dressers were not entirely happy with their position. An obscure "Ermelinda-affair" prompted Phillip to seek an exit from the Mahenge mission hospital. He had in time contracted a 'sort of leprosy', and was refused entry into the army services. The Mission was prepared to release him, but feared that Faustin, the other dresser, would also want to leave

[194] TNA 61/645: District Office Mahenge, *Letter to Dir. of Med. Services. Mahenge, 30.03.1940*; TNA 26367: R.R. Scott, *Letter Dir. of Medical Services to Chief Secretary DSM, 17.05.1940*.
[195] PAL Sch 1061.5 Mappe 4 darin "tempus 1940": Alois W. Gabathuler, *Letter to E. Maranta. Mahenge, 03. 02.1940*.
[196] TNA 61/231G: E.J.W. Carlton, *Letter of ADO i/c to Dir of Med Services. Mahenge 02.02.1940*.
[197] PAL Sch 1061.5 Mappe 4 darin "tempus 1940": Maria J. Gabathuler, *Letter to E. Maranta. Mahenge, 29.01.1940*.
[198] TNA 61/231G: E.J.W. Carlton, *Letter of ADO i/c to Dir of Med Services. Mahenge 02.02.1940*. The Capuchin school St. Joseph at Dar es Salaam had a firm hold in the Goanese community in Dar es Salaam: Bernadette Sr. Gabler, *Missionsarbeit der Schwestern von Baldegg in Daressalaam (Ostafrika)*, in Katholisches Missionsjahrbuch der Schweiz, 1935. Alois W. Gabathuler, *Bericht Dr. Gabathuler-Leins, Mahenge, Ost-Afrika*, in Missionsärztliche Caritas, 1940; PAL Sch 1061.5 Mappe 4 darin "tempus 1940": Alois W. Gabathuler, *Letter to E. Maranta. Mahenge, 17.03.1940*.
[199] TNA 61/231G: E.J.W. Carlton, *Letter of ADO i/c to Dir of Med Services. Mahenge 01.03.1940*.

once Phillip did.[200] Both men eventually remained in the Mission Hospital up to the moment it was given back to the Government. At that time, they left the hospital abruptly, leaving Gabathuler shocked at the loss at such short notice. A.T. Culwick, the District Officer, sent an angry letter to the Mission which he felt was behind their sudden desertion.[201]

From the beginning, Gabathuler wanted to entrust much of the medical work to nuns. But from August 1940, Gabathuler had only one white sister in the 'Native hospital'. Eleven black "boys" and "half-white" girls did much of the work.[202] In-patients would be put under the care of nuns; the distribution of food, preparation of drugs, and laboratory work fell under the Baldegg sisters. For the first time in the history of the Mission, Baldegg nuns worked in a Mission Hospital under a resident doctor. From the very beginning, Gabathuler considered that his "most important order for my hospital for this year would be a good nurse."[203] It is clear, however, that even with the last minute stalling of the hospital lease, there was absolutely not enough time to train and send out new nurses from Baldegg. Maranta had been refused new nurses because the congregation had just built and opened in 1940 a district hospital with a training school for nurses in Sursee, a local centre for the Luzern hinterland, and there were no nurses to spare.[204] The older generation of Baldegg sisters at hand in Mahenge constituted a major problem in Gabathuler's view.

Gabathuler considered one of the sisters to be "utterly incapable" of performing the assigned medical tasks. "She can," Gabathuler lamented, "help during consultations, do dressings, and distribute medications. But even for the latter duty, one has to permanently supervise her […] often she is obstinate and not at all interested in learning."[205] Gabathuler also criticized the dispensary in Kwiro as the worst in the entire Mission. "I am sorry to say," he wrote to the Bishop, and continued:

> "but it is really because of the lack of a capable sister. Look at the dispensary of Sr. Judith [Bannwart], which is really a treasure trove, simple but always clean and well organized. The same you can say about Ifakara, Msimbazi and Sofi, and even in bush of Kipatimu. Sr. [anonymized] may have been a nurse for 13 years, and has done – at least partially - the course at Baldegg, but she practically doesn't understand anything about diseases and their treatment. There is more to this work than just dressing wounds, handing out anti-cough medicine and Tyhmol against hookworm. Its mostly about a good and practical view,

[200] PAL Sch 1061.5 Mappe 4 darin "tempus 1942": Alois W. Gabathuler, *Letter to E. Maranta. Mahenge 27.06.1942*.
[201] PAL Sch 1061.5 Mappe 4 darin "tempus 1943": A. T. Culwick, *Note to Kwiro Mission. 30.07.1943*; PAL Sch 1061.5 Mappe 4 darin "tempus 1943": A. T. Culwick, *Note to Kwiro Mission. 31.07.1943*.
[202] Institutsarchiv Baldegg B III 5,2: Sr. M. Luitberta Bucher, *Letter to Wohlerwürden Fr. Mutter. Kwiro 15.12.1940*.
[203] PAL Sch 1061.5 Mappe 3 darin "tempus 1939": Alois W. Gabathuler, *Letter to E. Maranta. Mahenge 14.05.1939*.
[204] PAL Sch 1061.5 Mappe 3 darin "tempus 1939": Edgar Maranta, *Letter to A.Gabathuler. 30.05.1939*.For Sursee see: Stefan Röllin et al., *Sursee und sein Spital*, 1990; Regierungsrat des Kantons Luzern, *B 60: Botschaft des Regierungsrates an den Grossen Rat zum Entwurf eines Dekrets über die Überführung der Baldegger Schule für Gesundheits- und Krankenpflege Sursee in die kantonale Trägerschaft, 24.08.2004*, (Luzern2004).
[205] PAL Sch 1061.5 Mappe 3 darin "tempus 1939": Alois W. Gabathuler, *Letter to E. Maranta. Mahenge 14.05.1939*.

> cleanliness and order in every way, a sensibility for sterile work, a knowledge about drugs [...]. Its difficult to teach this to an old nurse."[206]

Maranta was not happy with the criticism. "Why", he asked, "don't you write about the other nurse in Kwiro, who is a very good one and about the one we sent up there, Luitberta, with the sole task of assisting you?"[207] Indeed, Gabathuler was excited about the medical capabilities of this new nurse, Sr. Luitberta, but she was sickly at the beginning of her long service in Tanganyika.[208] She appreciated the fact that she was able to learn much more in the hospital in Africa than she would ever have in Switzerland.[209] A second sister, Sr. Andresa, had been claimed by P. Gerard for the mission school.[210] Maranta became wary about the fast pace of changes Gabathuler might instil in the dispensaries, too:

> "I am entirely ok with you re-ordering things on the stations, especially where there are sisters. But please proceed slowly and with care. These sisters have worked for many years on these posts, they believe in their considerable achievements with these methods of theirs and would take it personal if you were to go against them too harshly, [...] When joy of work and occupation is being shattered, one loses more than can be gained by financial saving."[211]

Gabathuler's conflicts with nurses were medical but involved the mission, and the image of the mission. While nuns were backed by their motherhouse, the Gabathulers had more leverage on the secular nurse and midwife, Regenbrecht. In mid-1940 Maria Gabathuler was pregnant and ill with a heart problem. Regenbrecht obviously felt under pressure from the Gabathulers and felt she was being treated as if she were their 'private nurse'. Finally, in reaction to a written complaint by an African patient, Maria Gabathuler publicly shouted at the nurse "in front of Blacks". [212] Maranta sided with Regenbrecht and defended her professional reputation.[213] He fully understood that Regenbrecht was intolerant towards this kind of dressing-down. He also supported Regenbrecht in a dispute about medicalized birthing. While the Gabathulers wanted births to happen in the hospital, Regenbrecht went to assist a birth in a hut. Maranta again took a position on this medical matter and declared that births should be attended at home as long as the women refused to come to the hospital. Gabathuler felt betrayed, seeing that Maranta conferred with Regenbrecht and allowed Regenbrecht to follow

[206] PAL Sch 1061.5 Mappe 3 darin "tempus 1939": Alois W. Gabathuler, *Letter to P. Veit. Mahenge, 14.01.1939*. PAL Sch 1061.5 Mappe 1: Alois W. Gabathuler, *Copy of letter of 29.01.1939 [printed in Katholische Missionsärztliche Fürsorge, Jahresbericht 1939]*.
[207] PAL Sch 1061.5 Mappe 1: Edgar Maranta, *Letter to A. Gabathuler. DSM 23.10.1939*.
[208] PADSM Box 176/Kwiro Chronik 1: *Kwiro Chronik 1902-1952*, p. 146, left side; PAL Sch 1061.5 Mappe 3 darin "tempus 1939": Alois W. Gabathuler, *Letter to E. Maranta. Mahenge 14.05.1939*.
[209] Institutsarchiv Baldegg B III 5,2: Sr. M. Luitberta Bucher, *Letter to Wohlerwürden Fr. Mutter. Kwiro 15.12.1940*.
[210] PAL Sch 1061.5 Mappe 3 darin "tempus 1939": Alois W. Gabathuler, *Letter to P. Veit. Mahenge, 14.01.1939*.
[211] PAL Sch 1061.5 Mappe 3 darin "tempus 1939": Edgar Maranta, *Letter to A.Gabathuler. 30.05.1939*; PAL Sch 1061.5 Mappe 1: Edgar Maranta, *Letter to A. Gabathuler. DSM 23.10.1939*; PAL Sch 1061.5 Mappe 3 darin "tempus 1939": Alois W. Gabathuler, *Letter to E. Maranta. Mahenge 14.05.1939*.
[212] PAL Sch 1061.5 Mappe 1: Alois W. Gabathuler, *Letter to E. Maranta. Mahenge, 08.07.1940*. PAL Sch 1061.5 Mappe 4 darin "tempus 1940": Edgar Maranta, *Letter to A. Gabathuler. DSM 09.06.1940*. PAL Sch 1061.5 Mappe 3 darin "tempus 1939": Alois W. Gabathuler, *Letter to P. Guido. Mahenge 17.12.1939*; PAL Sch 1061.5 Mappe 4 darin "tempus 1940": Alois W. Gabathuler, *Letter to E. Maranta. Mahenge, 03.06.1940*.
[213] PAL Sch 1061.5 Mappe 4 darin "tempus 1940": Edgar Maranta, *Letter to A. Gabathuler. DSM 09.06.1940*; PAL Sch 1061.5 Mappe 1: Edgar Maranta, *Letter to A. Gabathuler. DSM 23.08.1940*.

her own medical procedures.[214] Maranta's support of Regenbrecht did not deter Gabathuler from firing the nurse for 'negligence' in an anesthetics procedure during an operation in which course the patient died.[215] The replacement of Regenbrecht with two female secular nurse assistants did not improve the situation.[216] Gabathuler sometimes gave vent to his frustration with the patients, which seems to have given him a reputation for the open neglect of some patients.[217] He was also unable to settle with Maranta who had forbidden them to treat private patients in the Mission Hospital. As the end of their five-year contract neared, the Gabathulers became nervous that their contract would not be prolonged in mid-1943.[218]

## Another doctor for the mission – similar conflict lines

Maranta's position had become stronger with the arrival of Dr. Schuster in Kwiro, although this doctor was only there for a holiday of a couple of months, and did not intend to do any medical work. She would eventually take up a position as the doctor at the school – the position Gabathuler had refused.[219] Dr Adelheid Schuster had entered the service of the Capuchins at the very end of 1938. She had worked for the Catholic Benedictine Mission in Lituhi, on the shores of Lake Malawi before.[220] She arrived exhausted from this work and frustrated by the way she was forced to leave her work with the Benedictines.[221]

Because of her work at Lituhi, Schuster had experience of working on the periphery of biomedicine. She liked to use the microscope as a means of enlightenment on the non-witchcraft causation for disease.[222] She was aware that she had minimal knowledge in surgery, and wanted to train better in this field.[223] The Capuchins posted her at Kipatimu.[224] The acquisition of the services of Dr Schuster must have seemed a great asset to the Mission who profited from the support the doctor (she herself willing to work for mere pocket money) received from the Medical Department.[225] Soon, however, severe conflicts led to her temporary removal from the

[214] PAL Sch 1061.5 Mappe 1: Alois W. Gabathuler, *Letter to E. Maranta. Mahenge, 21.08.1940*.
[215] PAL Sch 1061.5 Mappe 1: Alois W. Gabathuler, *Letter to E. Maranta. Mahenge, 21.07.1940*; PAL Sch 1061.5 Mappe 1: Alois W. Gabathuler, *Letter to E. Maranta. Mahenge, 21.08.1940*.
[216] Institutsarchiv Baldegg B III 5,2: Sr. M. Luitberta Bucher, *Letter to Wohlerwürden Fr. Mutter. Kwiro 15.12.1940*.
[217] In 1946 Maranta gives six examples from 1942. PAL Sch 1061.5 Mappe 1: Apostolisches Vikariat DSM et al., *Opposition [to Agenzia Fides, Vaticano] DSM 28.06.1946*.
[218] MIW File Maria Leins-Gabathuler: F. Gabathuler, *Letter to MI Würzburg, Stuttgart 01.08.1942*.
[219] TNA Acc.450/HE/178/16: Adelheid Schuster, *Letter to Director of Medical Services, Kwiro 01.09.1944*.
[220] Maria-Hugo Schuster, *Im ersten Jahr am Nyassa-See*, in Missionsärztliche Caritas, 1938; Ansgar Häne, *Vom Dienst an den Kranken in der Mission der Schweizer Kapuziner im Vikariat Daressalaam*, in Missionsärztliche Caritas, 1939; TNA Acc.450/HE/178/16: Edgar Maranta, *Letter to Direct. of MS, DSM 19.01.1939*; PAL Sch 1061.5 Mappe 3 darin "tempus 1939": Adelheid Schuster, *Letter to E. Maranta. Kipatimu 04.02.1939*.
[221] PAL 1061.4: Adelheid Schuster, *Letter to P. Odo.(OSB). Kipatimu 04.02.1939*.
[222] Maria-Hugo Schuster, *Im ersten Jahr am Nyassa-See*, in Missionsärztliche Caritas, 1938.
[223] PAL Sch 1061.5 Mappe 3 darin "tempus 1939": Adelheid Schuster, *Letter to E. Maranta. Kipatimu 04.02.1939*.
[224] PAL Sch 1061.5 Mappe 3 darin "tempus 1939": Adelheid Schuster, *Letter to E. Maranta. Kipatimu 04.02.1939*. PAL 1061.4: Adelheid Schuster, *Letter to E. Maranta. DSM 15.09.1940*. Compare also her 5 year work on the marriage (and health) booklet. PAL 1061.4: Adelheid Schuster, *Letter to E. Maranta. DSM 15.09.1940*.
[225] TNA Acc.450/HE/178/16: Tanganyika Territory Director of Medical Services, *Letter to Senior MO, Lindi, DSM 04.12.1940*; TNA Acc.450/HE/178/16: Tanganyika Territory Director of Medical Services, *Letter to Senior MO, Lindi, DSM 30.08.1939*. PAL Sch 1061.5 Mappe 3 darin "tempus 1939": Adelheid Schuster, *Letter to E. Maranta. Kipatimu 04.02.1939*.

Kipatimu mission station. Confiding in Edgar Maranta, she related a story of mutual accusations and psychotic distress, and also of nationalist antipathies between the Swiss and the German doctor. There was even of a sort of professional resentment from the staff at Kipatimu. Schuster had forbidden him to continue with what she termed his "dispensing in a 'medical' manner of all kinds of powders and ointments to his private clients" in Kipatimu.[226] On the other hand, it seems that Schuster was reported as being harsh with patients, cutting rations in the leprosy camp and expelling patients when she ran into conflict with their families.[227] Dr. Schuster soon returned to Kipatimu where she tried to get the 'hospital' in shape, but felt 'sick in her soul' to the point of indicating that she preferred the war-time internment camp for 'enemy aliens' at Morogoro to remaining with the Mission.[228]

The layout of the conflict between the doctor and the missionary head in Kipatimu is so obviously similar to the situation in Mahenge, that it must be taken as a hint for structural and institutional, not just personal, issues, that lay at the roots of such conflict. A central theme in this was Schuster's status as a laic. Schuster felt belittled and hurt by the statement of a nun who told her that she was "not tied to Mission." Schuster asked if the spiritual contract she had entered into with God did not count either:

> "Isn't the mission doctor the one suffering the most for not being able to live a model life of an ecclesiastic? That she could not pretend to have wonderful healing powers with which to make her sheep happy? Isn't the serious doctor suffering more than anyone else that she cannot give as much as she wants, although she gives her all, and shouldn't this kind of bond with God not be as strong as any contract on paper?"[229]

Schuster's take was not so different from Gabathuler's, as she too had stopped her career in the German congregation at Tutzing, since "she did not find her way in that [particular] climate".[230] Schuster shared this feeling of being curtailed in her medical and religious authority with Maria Gabathuler, who had experienced nun-nurses making her life difficult as a young doctor in Europe.[231] The isolated communities in Kipatimua and Kwiro in the 1940s were like pressure cookers of conflict between laics and clerics from the Catholic world in Europe.

[226] PAL 1061.4: Adelheid Schuster, *Letter to E. Maranta. DSM 15.09.1940*.
[227] PAL 1061.4: P. Hilmar Pfenniger, *Letter to E. Maranta. Kipatimu 11.09.1941*.
[228] PAL 1061.4: Adelheid Schuster, *Letter to E. Maranta. Kipatimu 10.09.1941*. PAL 1061.4: Adelheid Schuster, *Letter to E. Maranta. Kipatimu 15.02.1942*.
[229] PAL 1061.4: Adelheid Schuster, *Letter to E. Maranta. DSM 15.09.1940*.
[230] Br. Wendelin Hasler, *[obituary] Frau Dr. Med. Adelheid Schuster, Missionsärztin*, in ite, 1989. She herself claimed that things went bad at Tutzing for one or even two thirds of the novices: PAL 1061.4: Fidelis Stöckli, *Frau Dr. Schuster, Köln [Besuchsnotiz, 09.02.1981]*.
[231] PAL Sch 1061.5 Mappe 3 darin "tempus 1935": Alois W. Gabathuler, *Letter to E. Maranta. Zürich, 03.07.1935*; MIW File Alois Gabathuler: Alois W. Gabathuler, *Letter to Becker, Zürich, 07.07.1935*. Being a female doctor was a role in which Maria Leins could be multiply suppressed. During her training she was subjected to the orders of younger and lesser trained and inexperienced male colleagues PAL Sch 1061.5 Mappe 3 darin "tempus 1937": Alois W. Gabathuler, *Letter to E. Maranta, Luzern, Kantonsspital, 07.07.1937*. The mission had wanted her to work not a s doctor, but as a nurse. 6309 und: PAL Sch 1061.5 Mappe 3 darin "tempus 1936": Alois W. Gabathuler, *Letter to P. Veit. Luzern, 02.06.1936*.

## The doctor must go

The Capuchins back in Switzerland regretted that the relationship between Maranta and Gabathuler was bad, but did not want to intrude into the affair as Gabathuler had been hired by Maranta's Catholic Vicariate and not the Swiss Capuchin Province.[232] But Gabathuler ran a hospital in a state of permanent conflict. After Maria Gabathuler had given birth to their child in 1940, she became gravely ill, and suffered a "heart attack" and saw her Mission medical career break.[233] Gabathuler continued to work as the mission doctor in Mahenge hospital.

The mission in Tanganyika now increasingly felt that Gabathuler's view on the British had become a political risk for the mission. The doctor was repeatedly heard to use rude words against the British, and rumours sprang up about his being a Nazi sympathizer.[234] The way in which Gabathuler tried to use his leverage as a doctor to pacifist ends sheds a slightly different light on the man.[235] In 1941 Gabathuler turned to Maranta because he felt in a moral conflict about his role as a medical expert for the recruitment of Wapogoro men for the colonial British army. By the terms of his contract he was ordered to assist, but he felt that the compulsory recruitment of these men was against missionary principles as well as against the neutrality the Swiss professed.[236]

Once Dr. Schuster had joined the community in Kwiro, the Mission had three doctors in Kwiro, but not one of them was a particularly dynamic workhorse for the Mission. No one could leave and no one really wanted to stay. Maranta informed Gabathuler in June 1942 that Schuster was coming to Kwiro and that he did not plan to extend the contract with the Gabathulers beyond May 1943.[237] Nevertheless, Gabathuler remained hopeful that the negotiations about his contract would produce, with the help of the Swiss home base of the mission, a successful settlement.[238] Indeed, it looks as if, for a moment, the Mission was under pressure to continue with Gabathuler for reasons of its standing with the Government.[239]

Eventually, the end came quickly in June 1943. The final blow was not linked to medical practice at all. Ironically, this time, Gabathuler had Maranta's support in the matter. The dispute was about the degree of cooperation the Mission was to offer the Government for the care of the Italian internees who were about to be transferred to Kwiro.[240] The Mission personnel and the

[232] PAL Sch 1061.5 Mappe 4 darin "tempus 1942": *Letter to Heinrich Gabathuler, St. Gallen. Olten? 09.07.1942*.
[233] PAL Sch 1061.5 Mappe 4 darin "tempus 1940": Alois W. Gabathuler, *Letter to E. Maranta. Mahenge, 17.03.1940*. PAL Sch 1061.5 Mappe 4 darin "tempus 1940": Alois W. Gabathuler, *Letter to P. Guido Käppeli. Mahenge, 27.03.1940*.
[234] PAL Sch 1061.5 Mappe 1: *Bemerkungen über die Angelegenheit Dr. Gabathuler*.
[235] I was told by a well informed person that he had seen Gabathuler's name on a list of former doctors in the Kantonsspital Luzern supplemented with a swastika, probably as a way to denounce Gabathuler and his German ties. At the time Gabathuler was in Lucerne, however, he was writing of Goebbels as being a 'devil'. PAL Sch 1061.5 Mappe 3 darin "tempus 1935": Alois W. Gabathuler, *Letter to E. Maranta. Zürich, 03.07.1935*.
[236] At least that is what he claims later.PAL Sch 1061.5 Mappe 1: A. T. Culwick, *Letter to E. Maranta. Mahenge, 30.05.1943*.
[237] PAL Sch 1061.5 Mappe 4 darin "tempus 1942": Edgar Maranta, *Memo to A. Gabathuler. n.d.*
[238] PAL Sch 1061.5 Mappe 4 darin "tempus 1942": Alois W. Gabathuler, *Letter to P. Guido Käppeli. Mahenge 07.12.1942*.
[239] PAL Sch 1061.5 Mappe 1: *file*, document dated 17.05.1943.
[240] PAL Sch 1061.5 Mappe 1: Edgar Maranta, *Letter to D.C. Kwiro 31.05.1943*.

doctors disagreed over the allocation of lodging, food entitlements, and responsibilities.[241] Faced with what seems to be the missionary community in Kwiro/Mahenge on the brink of emotional collapse[242], Maranta seems to have decided to draw a line and part ways for good with Gabathuler. The Gabathulers would later charge the Mission with the breach of a contract, and given the immediate circumstances of their departure, it does look as though the Gabathulers were the scapegoats at that particular moment. After all we have seen above, it was quite an unsurprising move on the part of Maranta to sever ties with the two medical persons, one of whom was the first Swiss Mission doctor to ever serve in a Catholic Swiss Mission.

## The mission leaves the hospital, the doctor stays behind

It was now evident that, on the political level, it was not Gabathulers' anti-British stance that constituted the problem for the Mission, but his conflict with the Mission itself and the fact that Gabathuler would side with the Government, and in particular with A.T. Culwick. After the sacking of the Gabathulers, Culwick complained that this constituted an:

> unspeakable calamity to this district [...] robbing us of skilled medical personnel we can ill afford to lose [...] when we are in the middle of the biggest Sleeping-Sickness and public health programme ever attempted here.[243]

Against these medical arguments, Maranta explained that it was Gabathuler's "attitude to the mission" which was inacceptable.[244] He also made a half-hearted suggestion that Schuster could take over the Hospital if she felt capable of doing so.[245]

It soon became impossible for the Mission to hang onto the Hospital. The Gabathulers were out of the Hospital, promising a good handing over and assistance to Schuster.[246] But Schuster did not want to take over the Hospital.[247] While Maranta, after her refusal, successfully prevented the Government from forcing her to take up a position in another part of the country[248], Gabathuler was cleared by the Government of all security concerns, was given a contract with the Government, and the Hospital was given back to the Government.[249] The

[241] PAL Sch 1061.5 Mappe 1: *[documents re: conflict over medical treatment for Italian internees]*.
[242] The 'resignation' visible in Maranta's impressive reply to complaints from Kwiro: PAL Sch 1061.5 Mappe 4 darin "tempus 1943": Edgar Maranta, *Letter to P. Manfred. DSM 19.07.1943*.
[243] PAL Sch 1061.5 Mappe 1: A. T. Culwick, *Letter to E. Maranta. Mahenge, 30.05.1943*. Not much later, Maranta shared his grudge about Culwick: PAL Sch 1061.5 Mappe 1: Edgar Maranta, *Letter to P. Manfred. DSM 09.08.1943*. PAL Sch 1061.5 Mappe 1: A. T. Culwick, *Letter to E. Maranta. Mahenge, 23.05.1943*. My reading of the two letters dated on the same day in Mahenge and Kwiro is that Maranta told Gabathuler, Gabathuler told Culwick who then reacted to Maranta. There is no doubt that Maranta wrote a clear statement that the contract was not renewed after 3 June 1943. PAL Sch 1061.5 Mappe 1: Edgar Maranta, *Letter to A. Gabathuler. DSM 23.05.1943*.
[244] PAL Sch 1061.5 Mappe 1: Edgar Maranta, *Letter to D.C. Kwiro 31.05.1943*.
[245] PAL Sch 1061.5 Mappe 1: Edgar Maranta, *Letter to P. Manfred. DSM 09.08.1943*.
[246] PAL Sch 1061.5 Mappe 1: Edgar Maranta, *Letter to A. Gabathuler. Kwiro 31.05.1943*; PAL Sch 1061.5 Mappe 4 darin "tempus 1943": Alois W. Gabathuler, *Letter to A.Schuster. Mahenge, 30.05.1943*; PAL Sch 1061.5 Mappe 4 darin "tempus 1943": Alois W. Gabathuler, *Letter to D.O Mahenge. Mahenge, 30.05.1943*; PAL Sch 1061.5 Mappe 4 darin "tempus 1943": Alois W. Gabathuler, *Letter to E. Maranta. Mahenge, 28.06.1943*.
[247] PAL Sch 1061.5 Mappe 1: Edgar Maranta, *Letter to Director of Medical Services. DSM 22.08.1943*.
[248] PAL Sch 1061.5 Mappe 4 darin "tempus 1943": R.R. Scott, *letter to E. Maranta. DSM 26.08.1943*.
[249] TNA 26367/Mahenge Hospital: Tanganyika Secretariat DSM, *Notes Re: Hospital Mahenge, lease of land, employment Gabathulers, Re-building of Mahenge Hospital*; TNA 26367: R.R. Scott, *Letter Dir. of Medical Services to Chief Secretary*

Indian community at Mahenge saw medical services in peril and sent a petition to the Government asking that it should ensure the provision of good medical services at Mahenge: "We expect that government and the mission will cooperate in this matter [for] the good of the community."[250] But the Mission community believed itself to have priority over everyone else at that moment.[251] Consequently, the Mission announced the withdrawal of its staff from the Hospital – or, rather, of the service under Gabathuler and promptly stripped the Hospital of much of its staff, including sister Luitberta who came close to a nervous breakdown.[252] In a bitter fight, the missionaries in Mahenge quickly tried to secure their share of drugs and equipment from the Hospital, for the treatment of the missionaries and Mission pupils.[253]

Alois Gabathuler now held a position as a sort of Government doctor. In this position, he continued to defend medical principles versus a traditional Catholic moral system: the example we know of is his opposition to the public denunciation of a female pupil at the mission school because she had contracted Syphilis: "From a medical perspective I have to oppose categorically that patients with an STD, are being stigmatized publicly." The disease could be healed, Gabathuler pointed out.[254]

In 1944, Alois Gabathuler took stock of

> "five years in mission service: 1. We have lost our ideals and in part also our faith. […] 2. one should not enter into contracts with church institutions, especially not as a laic, because this only gives you duties, but no rights. […] 3. five years of serious and self-sacrificing work done you will be chucked out just like a dog, […5.] I am now 39 years old, without a job and with no possibility to travel home. What have I achieved? Maybe a couple of thousand Swiss Francs, that might not be worth anything once the war is over, I don't have a practice etc…."[255]

In December 1946, Alois and Maria Gabathuler and their daughter left Mahenge and returned to Switzerland.[256] Gabathuler entered into the legal struggle with Maranta. He had not entirely broken with his professional identity as a Mission doctor however. From Switzerland, he even applied for another job as a missionary in Tanganyika with the Mission of the White Fathers. But, eventually, the family settled with their own medical practice on the outskirts of Luzern.[257]

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*DSM, 21.06.1943*; PAL Sch 1061.5 Mappe 4 darin "tempus 1943": R.R. Scott, *Memo to E. Maranta. DSM 14.06.1943*; TNA 61/645: Dept. of Lands and Mines Tanganyika Territory et al., *Letter to Dir. of Med. Services. 26.08.1943 re: Mahenge Hospital*.

[250] PAL Sch 1061.5 Mappe 4 darin "tempus 1943": *Letter to D.O. Mahenge. Mahenge, 05.06.1943*.

[251] PAL Sch 1061.5 Mappe 4 darin "tempus 1943": P. Manfred, *Letter to A. und M. Gabathuler-Leins. Kwiro 13.08.1943*.

[252] PAL Sch 1061.5 Mappe 1: Edgar Maranta, *Letter to P. Manfred. DSM 02.08.1943*; PAL Sch 1061.5 Mappe 4 darin "tempus 1943": Bertram Wilkin, *Letter ASMO to DMSS. Mahenge, 09.08.1943*.

[253] PAL Sch 1061.5 Mappe 4 darin "tempus 1943": R.R. Scott, *letter to E. Maranta. DSM 20.08.1943*; PAL Sch 1061.5 Mappe 4 darin "tempus 1943": Bertram Wilkin, *Letter ASMO to DMSS. Mahenge, 09.08.1943*.

[254] DAK folder "Correspondence: Ifakara Mission 1941-1944": Alois W. Gabathuler, *Letter to Pater Hieronymus, Gvt. Hospital Mahenge, 26.09.1944*. Similar letters we can find, too, e.g. to P. Thomas on the disease "Roho inanuma" on 17.03.1940 in DAK "Briefe" [strikethrough: "gnädigster Herrn DSM"]

[255] MIW File Alois Gabathuler: Maria J. Gabathuler, *Letter to MI Würzburg. Mahenge, 11.03.1944*.

[256] PADSM Box 176/Kwiro Folder 2: *Chronik Kwiro*.

[257] MIW File Alois Gabathuler: Maria J. Gabathuler, *Letter to MI Würzburg. Uznach, 16.11.1947*.

## Demedicalization in the Mission

The Mission continued to deliver medical services in Ulanga and, in the person of Adelheid Schuster, it still had a doctor to do so. The kind of conflicts we have seen also continued. Towards the end of the 1940s, the Government raised the medical standards Missions had to meet in order to receive grants in drugs and money. Dr. Schuster clashed with the sisters in the dispensaries and even with Bishop Maranta. Maranta, who in general seems to have been quite welcoming towards Schuster, clearly differed with her on the issue of how much the Mission was to adapt to Government regulations – or, in other terms, on how much medical services delivered by the Mission were to be guided by (more or less) up-to-date scientific professional medical standards. Eventually, this resulted in hitting what must be considered the rock bottom of medical mission work during Maranta's Vicariate. In the years 1949 and 1951, the registration of the Baldegg nurses was put into question and, in that period, it seems from the sources available that the Roman Catholic Mission under Maranta was the only Mission body in Tanganyika to have experienced substantial cuts in the grants-in-aid by the Government for its failure to add a sensible amount of value in medical terms to the Government of the Territory (see chapter 8).

Schuster had tried to prevent just such a scenario by trying to establish some supervision over the dispensaries run by the nuns, but Maranta explicitly followed a pragmatic line of medicine which prioritized mission over scientific medical standards. The mission approach to expert knowledge in medicine, in any case, was that practical knowledge was worth as much as a university degree.[258] Not surprisingly, Schuster was often in conflict with the nuns. In Kipatimu, she had been in a conflict with the sisters about the authority of the doctor in medical matters.[259] In 1943, when Maranta had tried to clean up some of the entanglements in Kwiro by suggesting Dr. Schuster move to a practice in Ifakara, the medical doctor refused outright.[260]

> "I cannot, for professional reasons, accept a clause that I have to cede all midwifery work to the nun-nurse. […] this is in contradiction to the honor of my profession. No missionary doctor would ever sign such a contract that excludes him from any field of medical practice. The doctor is responsible for the medical work; age or experience do not change this hierarchy."[261]

Maranta always defended what he called the "sometimes unorthodox" work of Sr. Arnolda. When Schuster argued for conformity to the requirements for grants, he explicitly defended the way of the missionary medical services and the way the Mission made liberal use of the grant funds.[262]

[258] *Die Schweizer Kapuziner in Afrika. Jahresbericht 1937*, 1937, p. 25.
[259] PAL 1061.4: Adelheid Schuster, *Letter to E. Maranta. DSM 15.09.1940*.
[260] PAL 1061.4: Adelheid Schuster, *Letter to E. Maranta. Mahenge 05.07.1943*. Schuster felt that the sisters were not calling on her for the medical work in the Kwiro girls' school and she was in conflict not only with Gabathuler, but also with the headmistress of that school. PAL 1061.4: Adelheid Schuster, *Letter to E. Maranta. Kwiro 17.06.1944, 03.12.1944*.
[261] PAL 1061.4: Adelheid Schuster, *Letter to E. Maranta. Mahenge 05.07.1943*.
[262] PAL 1061.4: Edgar Maranta, *Letter to Dr. A. Schuster. DSM 18.12.1947*.

In the medical practice of the priests and sisters on the Mission stations, Schuster saw many outdated and inefficient practices. Sisters would continue to work against the official guidelines in treatment and in the use and dosage of drugs, they would make incorrect diagnoses and then use outdated treatment. Schuster criticized the waste of drugs, as well as a general resistance to the maintenance of medical registers of both drug use and patient histories.[263] Sometimes she saw a capable midwife work at a place where her specialized training was in little demand but where she was overloaded with basic nursing work.[264]

Schusters's visits were made hard for her by the sisters who seem to have passively and actively opposed her supervision.[265] Schuster claimed that the lack of regular supervision of the dispensaries by herself was held against both the Mission and herself by the colonial medical administration.[266] She felt supported by the Government doctors in her stand against the sisters who refused to acknowledge her authority. It is quite obvious that the Government did not trust the medical work of the Capuchins at that time, but it is not absolutely clear whether this medical work was really so much worse than that of other Missions, or if it was just that its weaknesses were not covered up as well. After many years of problems in delivering health care in Ulanga, it is certainly not amazing that the Government was unhappy with the Mission's activities in health care.

Schuster had warned Maranta that Government would not consider the Mission's "kind of mass work" as serious medical work.[267] Adding to this, the Mission's entitlement to grants was weakened even further owing the fact that there were already medical services in some of the places where the Mission was active, most notably in Kwiro.[268] Nor did it help that many of the nurses in the service of the Mission had a Swiss training and seemed to qualify for state registration as nurses only by the narrowest margin.[269] Maranta concluded pragmatically that the conditions for grants were impossible to fulfill: "these men at the medical department know just too well that [their conditions] are inept and they do not care [just as] they do not care to keep their own guidelines." According to Maranta, it was all just a charade "to create the impression for the United Nations and those at home that they are in control." Instead of checking the black market for sulphides, the Department would rather hinder the Mission to dispense the popular M&B tablets and penicillin. The regulations were fine in theory, but when there was not enough qualified staff, the mistakes in the Mission were tiny in comparison to the

[263] PAL 1061.4: Adelheid Schuster, *Letter to E. Maranta. Kwiro 21.05.1949*; PAL 1061.4: Adelheid Schuster, *Letter to E. Maranta. Kwiro 18.02.1951*; PAL 1061.4: Adelheid Schuster, *Letter to E. Maranta. Kwiro 02.09.1949*.
[264] PAL 1061.4: Adelheid Schuster, *Letter to E. Maranta. Kwiro 17.09.1947*.
[265] PAL 1061.4: Adelheid Schuster, *Letter to E. Maranta. Kwiro 21.05.1949*; PAL 1061.4: Adelheid Schuster, *Letter to E. Maranta. Kwiro 07.07.1950*.
[266] PAL 1061.4: Adelheid Schuster, *Letter to E. Maranta. Kwiro 02.09.1949*.
[267] PAL 1061.4: Adelheid Schuster, *Letter to E. Maranta. Kwiro 02.09.1949*.
[268] For a discussion of these grant issues in the early 1950s see chapter 8.
[269] PAL 1061.4: Adelheid Schuster, *Letter to P. NN. Kwiro 04.08.1953*; TNA Acc.450/HE/178/16: D.F. Heath, *Letter to the Secretary Swiss Capuchin Mission, DSM 18.07.1950*.

abuse in many other places. Besides, the Mission received grants for services that otherwise were "ultimately the concern and duty of the Government."[270]

The Capuchin Mission really lacked a vision for medical work at that time. They were the only Mission of which it was reported that there was "no information [...] of any development proposition".[271] Obviously disgruntled by Schuster putting pressure on him, Maranta told her to leave the Mission. If this was a low point for the medical work of the Mission, it was not yet its end. Maranta contacted the medical department for a new doctor.[272] In the end, a subdued Schuster retreated to Kwiro.[273] Meanwhile, Edgar Maranta was in Switzerland for the first time in 17 years and he sought "a new Mission Doctor" there.[274] Schuster eventually also went to Europe for a holiday and for training to Köln.[275] In 1954, she was back again in Kwiro. By that time Bishop Maranta had already introduced a new doctor in Sr. Arnolda's hospital, and Schuster was set to go to Kipatimu.[276]

# Conclusion

At the end of the 1930s, the Catholic Mission in Ulanga invested massively into medical work. This was not as much a development within the Mission organization itself as it was a result of emergence of the Catholic medical missionary movement as an interest group within the missionary movement. In Germany, this movement had produced a training institute in Würzburg which was able to turn out academically trained Catholic mission doctors and 'lend' them to Mission organizations. In Switzerland, the Catholic Swiss Association for Medical Mission, the "Schweizerischer katholischer Verein für missionsärztliche Fürsorge" had become a lobby for Mission medicine, headed by Catholic doctors who had rural practices or headed Catholic medical centres. It is very likely that their activities persuaded the Capuchin Mission to jump on the bandwagon of clinical Mission medicine. Certainly, the SKMV gave a large sum of money to the Capuchins to erect a hospital in East Africa. At the same time, the Government in Tanganyika Territory adopted policies of health care which medicalized welfare, even if is difficult to see how the Africans would have profited from these policies. Rather, as the example

[270] PAL 1061.4: Edgar Maranta, *Letter to A.Schuster. DSM 09.09.1949*; TNA 692: Mission Medical Commitee, *note on meeting, in DSM 01.1950*.
[271] Not numbered document entitled: "Eastern Province Medical Missions" in: TNA 450/1283/9: *file*.
[272] TNA Acc.450/HE/178/16: Tanganyika Territory Director of Medical Services, *Letter to Archbishop Maranta, DSM 29.05.1950*.
[273] PAL 1061.4: Adelheid Schuster, *Letter to E. Maranta. Kwiro 16.01.1950*; PAL 1061.4: Adelheid Schuster, *Letter to E. Maranta. Kwiro 16.02.1950*. TNA Acc.450/HE/178/16: P. Hilmar Pfenniger, *Letter to the Director of Medical Services, DSM 06.06.1950*.
[274] TNA Acc.450/HE/178/16: P. Hilmar Pfenniger, *Letter to the Director of Medical Services, DSM 06.06.1950*. Edgar Maranta, *Professpredigt in Baldegg*, in Providentia, 1950.
[275] PAL 1061.4: Adelheid Schuster, *Letter to E. Maranta. Köln-Hohenlind, St. Elisabeth Krankenhaus 17.12.1952*; PAL 1061.4: Adelheid Schuster, *Letter to E. Maranta. Köln-Ehrenfeld 10.10.1952*.
[276] PAL 1061.4: Adelheid Schuster, *Letter to E. Maranta. Kwiro 26.01.1954*.

of Tabora shows, the new policies, and their incomplete and inconsistent implementation impacted negatively on livelihoods and social security.

Investing in a doctor and a hospital was a different approach for the Mission from the *caritas* model that had shaped Tabora, where the Mission had hoped to build a Catholic community. Now, the community consisted of healthy young people looking at a future as a Catholic elite. The fact that the medical doctor saw fee-paying patients (seeking surgery) from the Indian and non-Christian communities before he saw the Catholic missionary led – in combination with a series of other factors – to a discordant situation between the doctor and the head of the Mission. It is necessary to look very closely at these conflicts in order to understand the structural dimension which lay beneath the surface of personal disputes.

The conflicts highlight a basic friction in the Mission medical enterprise, the clash between the secular and the spiritual. Not only did the ecclesiastical lay status of the medical newcomers put them in a marginal position, their professional medical habitus and perspective also put them in opposition to the established practices of medicine of the Mission.[277] Bishop Maranta valued the symbolic function of medicine as tool and token of a system that cared for people and invested in their health and healing. Medicine in the Mission was almost like the material articulation of a vision of hope, and the very practice of healing was more important than the strict adherence to the medical reference books.

I am quite convinced that the events in the Swiss Capuchin Mission triggered the Catholic missiology professor in Switzerland, Josef Beckmann, to write up a small study on the future of Catholic missionary medicine in 1944. Following the Swiss medical mission movement fairly closely, he had already published a small piece on "Medicine in the Catholic Missions in Africa" in 1943. In this piece, he stated how important the lay doctor was for the Mission enterprise.[278] About 40 lay Catholic doctors were active at the time in Africa (not counting the many doctors working in the joint Government/Mission hospital in the Congo). In his 1944 article, Beckmann dedicated a small study to about 20 of these doctors who, like Gabathuler, had come through the Missionsärtzliche Institut Würzburg.[279] Beckmann noticed that, of these doctors, at the time of writing, not one was working in the Mission any more.[280] Many had returned before the 10-year contracts were completed, and some had transferred to Government service (as Gabathuler had also just done). Beckmann argued that the "Catholic doctor" not only suffered in the tropical climate, but also that, as a specialist, the doctor was very lonely and too disconnected with the medical faculties. His professional costs were too high for the Missions to support, yet the

[277] As Walter Bruchhausen has observed, the mission medical doctors were new-comers and had no clear-cut space within the Catholic Church authority. Walter Bruchhausen, *Medicine Between Religious Worlds*, 2009, p. 181.
[278] Johannes Beckmann, *missionsärztliche Fürsorge in den katholischen Missionen*, 1943. For the following: pp. 3, 4.
[279] Johannes Beckmann, *Laienapostolat*, in Missionsärztliche Caritas, 1944.
[280] Which was not entirely true, as the two female Swiss doctors, Kunz and Hardegger, were both with their missions at that time. Beckmann seems to have largely neglected the impact of the war to make his argument more pertinent.

Missions too were greatly dependent on the services of the doctor, whose salary was unaffordable within the comparative financial structure of Mission wages.

Beckmann's argument reflected a general notion in interested Catholic circles that two major sciences, Theology and Medicine had been divorced by the necessities of specialization. "The Priest-Doctor in its full sense has become an Utopia," the president of the Swiss Catholic Association for Missionary Medicine (SKMV) had noted in the first number of the association's yearbook.[281] The Catholic Mission doctor needed to have a double calling, both as a missionary and also as a well-trained and dedicated doctor, physically fit for the work in challenging situations. In ecclesiastical terms, the Mission doctor would therefore be a layperson.[282] This was the concept that Christophorus Becker pushed in the Missionsärztliche Institut in Würzburg, a concept and principle which Alois Gabathuler specifically pointed out in an obituary on Becker.[283] The propagandists and promoters of doctors in missionary medicine, like Becker, Beckmann and the SKMV proposed to free the Mission doctor from the Mission society. But the promise of autonomy was problematic: it could turn a doctor in the Mission into an alien within the Mission organization to the point that Beckmann suggested, in his study in the mid 1940s, that maybe the solution was to have Catholic doctors 'in the colony' rather than in the Mission organization itself.[284] This suggestion by a leading mission scholar shows that in the mid 1940s it was possible to think of dropping scientific medicine from the portfolio of a Catholic mission organization. Certainly, in the Capuchin Mission, the late 1940s witnessed the nadir of Mission medicine.

As a consequence of the ill-fated attempt to enter the world of the modern hospital, the Mission seemed to lose its important position in the curative medical system in Ulanga from the mid-1940s, culminating in the cancellation of government subsidies at the beginning of the 1950s. It had once looked as if the Mission could dispense almost all curative medicine in the district, with the district officer and not a medical specialist in charge of the rudimentary public health sector. Now, it was evident that the Mission was incapable and utterly unwilling to invest in either the financial or the technical dimensions of a secular and medical enterprise aimed primarily at the remedy of health deficiencies in an entire population. It illustrates the limits of mission medicine: the medical would, when push came to shove, not take priority over the Church. It also shows that these institutions also needed favourable personal relationships between individuals if they were to prosper. The human side of the institution could accentuate "institutional malaises" (in the words of Charles Good).

[281] hr, *Missionsärztliche Fürsorge*, in Missionsärztliche Caritas, 1935.
[282] J.K., *Kongressbericht [8. Internat. Akad. Missionskongress, Fribourg 30.07.1932-03.08.1932]*, in Jahrbuch des Akademischen Missionsbundes Freiburg, 1932.
[283] Alois W. Gabathuler, *Univ. Prof P.Dr. Christophorus Becker S.D.S*, in Missionsärztliche Caritas, 1938.
[284] Johannes Beckmann, *Laienapostolat*, in Missionsärztliche Caritas, 1944.

In the early 1950s, the tide turned rapidly, as we shall see in the next chapter. Now, the Mission, headed by the same people, would start a great investment into hospital services – no longer at its spiritual centre Kwiro/Mahenge but in Ifakara, the hub of trade and modernization in Ulanga.

# Chapter 7 The Missionary Answer to the Late Colonial Situation

Throughout the 1940s, the intellectual and governmental grip of British officials in Africa was increasingly troubled by the collapse of their institutions of governance in the face of a new pitch in African demands for power. Great economic hopes in the immediate post-War years soon plummeted in the face of collapsing world-market prices. [1] Now indirect rule failed to produce even a promise of stability for colonial rulers. 'Development' was called in as a measure to establish control over political and social development and in order to foster economic growth. Development fared no better in establishing effective control, however.[2] Development projects did not take-off, as we have seen in the case of the Ulanga development programme under A.T. Culwick in the late 1940s, or they crashed like the famous groundnut scheme.[3] At the same time, the idea of advancement and development motivated claims and fostered expectations amongst a growing section of the African population.[4] Producing new problems and unable to cool expectations at the same time, the 'new colonialism' or 'second colonial occupation' in the 1950s sank into political unrest and came to a rather abrupt end with the rapid decolonization of Tanganyika.[5] In December 1961 Tanganyika became a sovereign

[1] Andreas Eckert, *Herrschen und Verwalten*, 2007, p. 109. John Iliffe, *Modern History of Tanganyika*, 1979, chapters 13-16. For an economic and political history of this period see Andrew Coulson, *Tanzania. A political economy*, 2013 [1982], pp. 90-111. TNA 450/1623: Tanganyika Territory Ministry of Health, *Annual Report of the Medical Department for year 1958*.

[2] Michael Jennings, *Building Better People*, in Journal of Eastern African Studies, 2009; John Iliffe, *Modern History of Tanganyika*, 1979, chapter 14. Andreas Eckert, *Herrschen und Verwalten*, 2007, pp. 62-103. Kimambo's study on Pare district shows the failure of late colonial development plans to control popular feelings and the coming apart of colonial structures: Isaria N. Kimambo, *Penetration and Protest*, 1991.

[3] See chapter 4 for Ulanga. On the groundnut scheme see: Michael Jennings, *Building Better People*, in Journal of Eastern African Studies, 2009, p. 108n105. John Iliffe, *Modern History of Tanganyika*, 1979, pp. 440-443; Michael Havinden et al., *Colonialism and Development*, 1996, pp. 276-283; Rohland Schuknecht, *British Colonial Development Policy*, 2010, pp. 209-217.

[4] Gregory Maddox et al., *Introduction*, 2005; Frederick Cooper, *Decolonization and African Society*, 2005 [1996]; James Ferguson, *Expectations of Modernity*, 1999.

[5] John Iliffe, *Modern History of Tanganyika*, 1979, p. 436. The term was coined in D. Low and J. Lonsdale, "Introduction," In D. Low and A. Smith, eds. The Oxford History of East Africa. (Oxford: University of Oxford Press, 1976), 1-64. Frederick Cooper, *Decolonization and African Society*, 2005 [1996], chapter 4 pp. 110 ff. John Iliffe's account of the acceleration of

nation within the Commonwealth, and just a year later it adopted a republican constitution. This chapter looks at the post-war years and explains how the Capuchin mission answered the new situation and the challenges it entailed.

We begin with a discussion of the transition of the late colonial state into a national one, and show how modern planning and development were central to the mode of operation of the state. Then we look at how the Capuchin Mission reacted to the challenges of nationalism, by pushing Christians to retain the institutions established under colonial rule and by establishing new institutions. We will see that, in Ulanga, hopes for development and the challenges faced by the late colonial institutions, including the mission, pushed the mission to invest in the modernization of their health services. In order to fully understand this, we must also look at later colonial health policies in Tanganyika and the state of medical services in Ulanga and how they created a long-term space for Church services in the health system.

## New Elites, the State, Planning and Developmentalism

Politically, decolonization was a complex process and those who lived through it saw many potential outcomes.[6] Even if development failed to secure colonial rule, in the context of decolonization it nevertheless established a central political goal for any future polity in Africa. Looking at rural Zambia, Henrietta Moore and Megan Vaughan described the young elite of the 1950s, amongst them Kenneth Kaunda, who

> "engaged in, and contributed to, an emerging discourse of development and progress. At times, they appeared to be doing the work of colonial officials for them-not because they were 'stooges' of any sort, but because they genuinely identified with, and saw their interests lying within, the colonial governments' postwar development strategy."[7]

Those who came to power in Tanzania as part of the process of decolonization were from the 'educated bureaucratic' class with a strong rural background.[8] The 'new' elite acted as interlocutors and gatekeepers for many crucial resources. It had internalized modernizing projects and, consequently, tried to build a state apparatus in order to push these ideas.[9]

At the centre of independence therefore stood a “basic consensus” between African elites and colonial powers that “Africa could not be imagined without a European-style state”.[10] Such a state rested on morals which Peter Ekeh called the "African bourgeois ideology of

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decolonization in the late 1950s and early 1960s is impressive John Iliffe, *Breaking the Chain*, 2005. John Iliffe, *Modern History of Tanganyika*, 1979, pp. 552-566.

[6] This argument is powerfully made by Frederick Cooper in many of his publications and in discussion with him in a workshop held with University of Basel students: Basel Graduate School of History et al., *Workshop with Prof. Frederick Cooper, New York University, Tuesday, 10.05.2011*, (Basel2011).

[7] Henrietta L. Moore et al., *Cutting Down Trees*, 1994, p. 113.

[8] Steven Feierman, *Peasant Intellectuals*, 1990, chapter 9; Andreas Eckert, *Herrschen und Verwalten*, 2007.

[9] Frederick Cooper, *Decolonization and African Society*, 2005 [1996]; Frederick Cooper, *Possibility and Constraint*, in The Journal of African History, 2008. Also Ralph A. Austen, *Colonialism from the Middle*, in History in Africa, 2011. And for the following: Andreas Eckert, *Herrschen und Verwalten*, 2007, pp. 12, 101-102.

[10] Christoph Marx, *Geschichte Afrikas*, 2004, p. 251. Or rather, the new elite proposed African self-government as an imagination of morally sound "English rule without the Englishman", as historian Dipesh Chakrabarty has coined it for Indian nationalism. Dipesh Chakrabarty, *Postcoloniality and the Artifice of History*, in Representations, 1992, p. 8.

legitimation".[11] Social differences between the colonial educated elite and the general population were bridged by nationalism and the nation state became the container in which general social development was to be articulated.[12] At the same time, the international arena was important for nationalism. In a recent study, Lohrmann has shown the UN as an "important catalyst" for Tanzanian nationalism because of the mandate-status of Tanganyika. Nationalists tried to secure UN support for decolonization and Julius Nyerere, president of the Tanganyika African National Union (TANU), learnt that he had to constitute the anti-colonial movement as a nation in order to be heard in the international arena.[13]

There is a striking continuity between the colonial territorial and local state and post-colonial nation states, and historians have brought forward a range of arguments about the historical continuity between the late colonial and the postcolonial state.[14] Mamdani has argued that the continuity was institutional, largely based on the separation of rights between traditional and modern spheres within the state – a continued rural/urban divide. Mamdani's view came under criticism from a number of historians, because it fails to point to which extent the political processes in the 1940s and 1950s the "the goal of development" served as the bridge between the late colonial und postcolonial states.[15] In fact, as the previous chapters have argued, the 'developmentalist' state had already developed by the late 1930s not least through the creation of the rural as a place where "natives" needed paternalist intervention on a large scale but also as a locus for claims of modern development and welfare state institutions. On the other hand, it would indeed take a couple of years after independence (in health matters, as we shall see, a full decade) until a 'developmentalist state' was firmly established in Tanganyika and was quite capable of intervention.[16]

Such a state could at least attempt to be a sort of an "imposing Leviathan", mobilizing the people in authoritarian ways. Scott's image of the high modernist state and his discussion of Tanzanian *Ujamaa* politics has had a wide impact on scholarship. Bonneuil reminds us how the

[11] Peter P. Ekeh, *Colonialism and the Two Publics in Africa*, in Comparative Studies in Society and History, 1975. Jonathon Glassman, *Slower Than a Massacre*, in American Historical Review, 2004; James R. Brennan, *Realizing Civilization*, in Social Identities, 2006.
[12] Christoph Marx, *Geschichte Afrikas*, 2004, p. 251. Nationalism in Tanzania in this period is discussed in Gregory Maddox et al., *Introduction*, 2005. Other chapters in this book show how nationalism terminology and feelings were quite ubiquitous in this period even where "party affiliation or activism was slight": Marcia Wright, *Local, Regional and National*, 2005, p. 164; Jamie Monson, *Tribal Past*, 2005, p.111.
[13] Ullrich Lohrmann, *Voices From Tanganyika*, 2007, pp. 545-546; David Piachaud, *Fabianism, Social policy and Colonialism*, 2010.
[14] Emma Hunter, *History and Affairs of TANU*, in International Journal of African Historical Studies, 2012, pp. 366-368, 383; James R. Brennan, *The Short History of Political Opposition*, 2005.
[15] Leander Schneider, *Colonial Legacies*, in African Studies Review, 2006, pp. 106-107. Susan Geiger, *Engendering & Gendering African Nationalism*, 2005, p. 285; Frederick Cooper, *Modernizing Bureaucrats*, 1997; Frederick Cooper, *[Review of:] Mamdani: Citizen and Subject*, in International Labor and Working-Class History, 1997; Frederick Cooper, *Decolonization and African Society*, 2005 [1996].
[16] Leander Schneider, *Developmentalism*, 2003, pp. 125-177; Andrew Coulson, *Tanzania. A political economy*, 2013 [1982], pp. 173-213. For an argument about the difficulties under which 'developmentalism' for African states is implemented see: Thandika Mkandawire, *Thinking about developmental states in Africa*, in Cambridge Journal of Economics, 2001.

Tanzanian case of villagization is not a singular event, but rather a typical element of developmentalism, in the colonial and post-colonial era.[17] What happened in the post-war period was a sort of gross accentuation of the scale of development projects and the intensity with which the state engaged, and was able to engage, in them.[18] From the late 1960s, Tanganyika/Tanzania is certainly a prime example of the developmentalist state, but the following chapters focus on the period of transition in the 1950s and 1960s.

Discourses about health played a major role in the new Tanzanian nation. In 1959, Julius Nyerere had voiced the motto of the "war against poverty, disease and ignorance": "We are not going into Government to make money. We are condemned to serve, to wage a war against poverty, disease and ignorance."[19] The "war" was also alluded to in Nyerere's preface to a history of the medical services in Tanganyika. Nyerere explained:

> "Our nation of Tanganyika comes into existence dedicated to fight a war – a war against poverty, ignorance and disease. For accidental reasons of geography and climate, tropical diseases are widespread; they sap the strength of the people and weaken their ability to play a full part in this struggle."

This national motto enlisted the elite, and the members of TANU in particular, into a war for development. The members of the single party were, according to the Arusha Declaration of 1967, "to see that the Government mobilizes all the resources of this country towards the elimination of poverty, ignorance and disease."[20]

It is important to understand the independent Tanganyikan state and its ideological base as a process. High modernism was not simply introduced at independence. We must not see the state as totally stable: decolonization opened new "moral arenas of political debate" as Lonsdale/Berman wrote in their Mau Mau study.[21] Michael Jennings has described a sort of 'pure' nationalism of the early 1960s, i.e. the time from independence to the Arusha declaration, when – one may assume in the positive emotional situation of having achieved independence – "self-help activities really flourished. At that moment of nation-building the 'good citizen' who truly engaged with national aims seemed to be a possibility.[22] It would quickly be seen, however,

[17] Christophe Bonneuil, *Development as Experiment*, in Osiris, 2000.
[18] Monica van Beusekom et al., *Lessons Learned*, in The Journal of African History, 2000, p. 31; Andrew Burton et al., *Introduction: The Emperor's New Clothes?*, in The International Journal of African Historical Studies, 2007, p. 6. Michael Jennings, *Building Better People*, in Journal of Eastern African Studies, 2009.
[19] Cranford Pratt, *The ethical foundation of Julius Nyerere's legacy*, 2002, p. 43, where Pratt quotes from his own 'the critical phase', p. 218. C. Pratt, *The critical phase of Tanzania, 1945-1968*, 1976. See also: Andreas Eckert, *Herrschen und Verwalten*, 2007, p. 136.
[20] Julius K. Nyerere, *The Arusha Declaration and Tanu's policy on socialism and self-reliance*, 1967, p. 2. Historians of Tanzania have worked intensively on the imagery of the Tanzania state and the many enemies it fought: see for example James R. Brennan, *Blood Enemies*, in The Journal of African History, 2006. Carol M. M. Scotton, *Some Swahili Political Words*, in The Journal of Modern African Studies, 1965.
[21] Bruce Berman et al., *Unhappy Valley*, 1992, p. 267. See also Gregory Maddox et al., *Custodians of the Land*, 1996, pp. 171-174.
[22] Michael Jennings, *Very Real War*, in International Journal of African Historical Studies, 2007. The 'good' citizen is the opposite of what Peter Ekeh described as the 'lucky' citizen, who happens to have access to the national state's resources: Peter P. Ekeh, *Colonialism and the Two Publics in Africa*, in Comparative Studies in Society and History, 1975, p. 108. Jennings shows how the leviathan state only came back in full force with the political changes taking place in Tanzania in the

that although Tanzania avowed an agenda of 'self-reliance', the country was one of the largest receivers of external development aid in the world.[23]

These contradictions become tangible in Ulanga and they showed how development and welfare institutions were reconfigured up to the late 1960s. As the reader will see in the following three chapters, the late-colonial project in Ifakara in the early years of Tanzanian independence was not carried by the colonial state or his successor, or even his bilateral partners, as much as it was carried by private actors.[24] We will, therefore, look for the kind of arenas created by medical institutions in Ulanga in which alternative moralities could be voiced, and where more than one reading of a developmentalist ideology could take hold and be articulated.

## Decolonization and the Missionary Factor

At the time of independence, the Capuchin mission and the Baldegg sisters had more than 200 members stationed in Tanganyika, of whom the majority lived and worked in Ulanga. The Mission employed an even greater number of African staff, on a regular or temporary basis. As a provider of social services in Ulanga, the Mission was in a position at least as strong as the state. This state employed, immediately before independence, police staff and game wards as well as a number of clerks who were African, as were the Native authorities, as well as the African dressers and the two Medical Assistants. Of the eight Europeans and two Asians who constituted the non-African personnel, only one was a Medical Officer. This rather small local state administration was considerably weakened by a scandal which saw the head tax clerk, Ali Athumani, being sacked for fraud, after much public discontent.[25] The structure of this state was further destabilized when decolonization offered the possibility to disentangle colonial institutions. The decentralization reform of government ("local government") initiated by and failed under colonial government in the late colonial period, was continued and failed in much the same vein by the independent state.[26] Native Authorities were dissolved at independence, with chieftaincy being officially suspended and replaced by Local Authorities in January 1963.[27] At the same time, the roughly 130 Swiss in the service of the Catholic Church in Ulanga served in an institution that was being decolonized and 'Africanized' at a pace that was different from that

late 1960s. Michael Jennings, *Very Real War*, in International Journal of African Historical Studies, 2007; Andrew Burton et al., *Introduction: The Emperor's New Clothes?*, in The International Journal of African Historical Studies, 2007, p. 19.

[23] Andrew Coulson, *Tanzania. A political economy*, 2013 [1982], pp. 313 in 1982 edition; Oscar Gish, *Planning the Health Sector*, 1975, pp. 194-197.

[24] Michael Jennings, *Surrogates of the State*, 2008.

[25] Michael Longford, *Flags Changed at Midnight*, 2001, pp. 264-265, 291, 305, 367, the story of Ali Athumani on pp. 267-269. The Medical Assistants were Samson Mwauranda and Walter Mulaga.

[26] Andreas Eckert, *Useful Instruments of Participation*, in International Journal of African Historical Studies, 2007.

[27] Tanganyika National Assembly, *An Act to repeal the African Chiefs Ordinance, 01.01.1963*. In Ulanga many of important state administration posts remained in the hands of former chiefs, e.g. Lupiro was administered by the Njohole family.

of the state.[28] The extent to which development has served as a second form of colonization can be grasped from the sudden shortage of experts and doctors the country witnessed when Britain pulled out and the colonial staff left Tanganyika.[29] As soon became clear, the new nation had a serious problem with 'modern' expertise, but the Church institutions were there to stay and they rapidly brought in new professional staff and experts from Europe.

On the other hand, decolonization also brought Switzerland in a new relationship with Tanganyika. As the African nation entered the world of nation states, Tanganyika and Switzerland could enter into a bilateral partnership amongst states. With no little amount of mystification, Switzerland claimed 'neutrality' and that it had no historical burden of colonialism. Official Switzerland grew its ties to Tanzania slowly and very much through the channels of business and mission that had been established in the colonial period, but we can only look at this process in chapter 9. For the moment, we shall discuss the missionary reaction to decolonization.

Since the 1930s, missionaries increasingly feared that poor livelihoods exposed the African to proletarianization. When Swiss Catholic mission scholars in the mid 1940s looked at Africa, they saw the spectre of poverty and proletarianization against which they set up an agenda of development that centred on nurturing what the Mission considered a healthy family life sustained by the best from European civilization.[30] The Capuchin, Walbert Bühlmann, missiologist with a field experience in Ifakara in 1953-56, shared this view. He felt that the mission had a "task to salvage the solidarity within the kin, which used to be natural and to transfer it into the new era, now undergirded by Christian motivations".[31] It almost sounded like the Culwick's take on contained social change in Ubena of the Rivers, but with a decisive extra: Christianity. The path into Africa's future was one that left the negative side of the tribal life, that filled with the cult of demons and so on, and which also left behind colonial exploitation.[32]

In Ifakara as in most places in Africa at the time Christian and neo-traditional reform of kinship and morals was coming under increasing pressure however. The single most "pressing factor in mission and church affairs" in East Africa in the late colonial period was nationalism, John Stuart argues.[33] Adrian Hastings has shown white missionaries after WWII as being - as a collective - nervous about the speed with which African self-government approached.[34] Drawing on Hastings, David Maxwell explains that a "muted" missionary response towards African nationalism was, particularly in the case of Catholics, a result of their foreign status and theology

[28] See the critique of Crawford Young in John Darwin, *What was the late colonial state?*, in Itinerario, 1999.
[29] John D. Hargreaves, *Decolonization in Africa*, 1988, pp. 100, 107-109.
[30] Johannes Beckmann, *Die katholische Kirche im neuen Afrika*, 1947, pp. 137, 139. Beckmanns references Westermann. Diedrich Westermann, *Afrika als europäische Aufgabe*, 1941, p. 115; Diedrich Westermann, *The African to-day and to-morrow*, 1949.
[31] Walbert Bühlmann, *Zwischen Mission und Pfarrei*, in Neue Zeitschrift für Missionswissenschaft, 1953, p. 34.
[32] Johannes Beckmann, *Die katholische Kirche im neuen Afrika*, 1947, pp. 22, 93, 109, 137-109.
[33] John Stuart, *British Missionaries and the End of Empire*, 2011, p. 7.
[34] Adrian Hastings, *A history of African Christianity 1950-1975*, 1979, pp. 94-100. Hastings even uses the term 'somewhat apolitical'.

which made them more hesitant to express political views. Maxwell's perspective highlights the fear of the churches about their being marginalized in the course of independence. This fear is a sign of the strength of secular political thought in the nationalist movement. It is also a sign of a lack of general acceptance of the mission churches among the general public. The elite who had been nurtured by the mission now "ignored the mobilizing potential of the churches, preferring to work with other institutions within civil society", Maxwell argues.[35] In a country like Tanganyika the church could count on a number of elite voices, and it could hope for a number of future leaders of the nation to come from its own training institutions. Some of these, amongst them Julius Nyerere, knew Bishop Edgar Maranta quite well.[36] To the Capuchin Mission Africa was a thus a continent that gave reason for a precarious kind of hope: "With the European loss of control in the middle and far East, all hopes lie with Africa," the editors of the Missionsbote wrote in 1950. Africa had been, in this narrative, the place from where resistance against Nazi Germany had got the upper hand, and which, with its mines and plantations "was now a prime economic armory" in a struggle against communism.[37]

At the same time, African citizens were perceived by the Mission as facing many new dangers. African self-government in the making paralleled European societies being both in trauma and in a rush of reconstruction, at the beginning of a "golden age" overcast by fears about the global communism. A feeling of uncertainty pervaded the mission, based on social 'problems' which were no longer related to Africa's wilderness, but to its dashing modernity.[38] The problem was the misbehaved and misguided African 'evolué': under the "dubious spell of modern civilization" "the superficially cultured [orig: kulturbeleckten] Bantu had developed a will to oppose and with [this particular kind of African] the problems moved in the African bush."[39] Even if race problems in Tanganyika were much less strongly articulated according to the missionary perception, the Kenyan Mau Mau resurrection left a mark on the Swiss observers. It stood as a typical scenario of communist exploitation of a crisis stemming from the "vital opposition of a primitive people against a revolution of the traditional social order."[40] The Mission tried in many ways to counter this dangerous path of social change. The church formed lay organizations, like the Legio Maria, where a life as an active Christian professing his virtues

[35] David Maxwell, *Decolonization*, 2005.
[36] in Missionsbote der Schweizer Kapuziner in Afrika, 1954, p. 55. William Redman Duggan, *A Study of Ujamaa and Nationhood*, 1976, p. 49.
[37] Red., *Einführung*, in Katholisches Missionsjahrbuch der Schweiz, 1950.
[38] *Zum Titelbild*, in Missionsbote der Schweizer Kapuziner in Afrika, 1955.
[39] Pater Jesuald Loretz, *Kwiro - die Stadt auf dem Berge 1902-1952. Und hell wirds in den schwarzen Köpfen - Die Kwiro Schule*, in Jahresbericht der Schweizer Kapuziner in Afrika 1952, 1952. P. Cyprian Zahner, *Mau-Mau*, in Missionsbote der Schweizer Kapuziner in Afrika, 1953.
[40] P. Cyprian Zahner, *Mau-Mau*, in Missionsbote der Schweizer Kapuziner in Afrika, 1953. P. Hilmar Pfenniger, *Hochwürdige Geistlichkeit! Verehrte Lehrerschaft!*, in Missionsbote der Schweizer Kapuziner in Afrika, 1953. On the topic of a sort of a communist hurricane about to kill a Catholic missionspring in Tanganyika see Red., *Einführung*, in Katholisches Missionsjahrbuch der Schweiz, 1957; *[Grafik] Kommunismus, Nationalismus, Materialismus und Säkularismus beherrschen heute die Welt. Müssen wir da die guten Kräfte nicht vereiningen, um das Reich Gottes auszubreiten?*, in Katholisches Missionsjahrbuch der Schweiz, 1958; Walbert Bühlmann, *Rote Keile im schwarzen Afrika*, in Katholisches Missionsjahrbuch der Schweiz, 1957.

offered an alternative model to trade union socialization and to nationalist aspirations.[41] Trade unionist and nationalists were cloaked in the language of anticommunism as "underground agitators and saboteurs" who pushed "red wedges" into society.[42]

The Catholic group of missionaries in Tanganyika were in general "unsympathetic to colonial rule and shortly before African independence [even] appear to have been involved in nationalist political activities".[43] The Capuchin Bishop Edgar Maranta, however, was not only the leading figure of the Swiss Capuchin Mission, but also the leader of the conservative and restrained wing of the Catholic Church in Tanganyika. De Jong suggest that Maranta was diplomatic but in reality rejected TANU which was coming into power and openly cautioned the Bishops to take a clear position on the upcoming vote towards independence.[44] As relations with the state remained undecided, the issue of religious freedom pushed into the foreground. In a private letter Maranta sent to a family member, he wrote: "to us it is of no importance whether the British or the African are in command. We only ask the liberty to preach the gospel and at the moment we still have this right."[45] For Maranta, the task of the Church was not decolonization but the stability of the faith in the process of political adjustments.

## Church and nation building

Towards the end of the 1950s, when Tanganyikan independence was foreseeable, Bishop Edgar Maranta re-published an article in the newly established *African Ecclesiastical Review*. The journal had been started in the same year with a programmatic editorial which reminded Christians that the Church needed "to heal the souls, not of individuals, but of nations and their future generations."[46] Maranta's article was based on a speech he had given in 1953 at an Eastern African conference about the role of African Catholic laics in the Church.[47] At the time of his speech, the Catholic Church in East Africa created the new hierarchy which meant that

[41] P.K.L., *Die Legio Mariae in unserer Mission*, in Missionsbote der Schweizer Kapuziner in Afrika, 1950.
[42] Walbert Bühlmann, *Rote Keile im schwarzen Afrika*, in Katholisches Missionsjahrbuch der Schweiz, 1957. Anticommunism was a long-standing topic with the Capuchin mission, see: P.V., *Eine harte Frage: Sind sie's wert?*, in Missionsbote der Schweizer Kapuziner in Afrika, 1934.
[43] T. O. Beidelman, *Social theory and the study of Christian missions in Africa*, in Africa, 1974, p. 238.
[44] Albert De Jong, *Mission and Politics*, 2000, pp. 152-154, 175-178. *Interview with P. Meinhard Inauen, Dar es Salaam, 28.01.2009*. The Swiss Capuchins were probably cautious towards most state officials. An example is Sr. Luitberta who was afraid that the smiles her hospital earned from the inspecting British District Officers could be fake: "In how many countries does it start like this, and all the sudden you sit behind bars, and don't even know why." PADSM Box 332 Baldegg Sisters correspondence - Bishops Sec: Sr. Luitberta *Letter to P. Oswin, Kipatimu, 16.09.1953*. The Capuchins would later support African Socialism: Ordenskommission der Franziskaner (OFMCap.), *Kasita-Erklärung*, in ite, 1970; Walbert Bühlmann, *Afrika*, 1963, pp. 188-189. For a study concluding that there was "obviously no conflict […] in contrasting the principles of Ujamaa socialism with the social teaching of the [Catholic] Church" see: John R. Civille, *A Study of Ujamaa*, 1976. See also John C. Sivalon, *Roman Catholicism*, 1990. Not very helpful Lloyd W. Swantz, *Church, Mission and State Relations*, 1965. On the relations between the Catholic Church and the post-independence Tanzanian political elite see: Frieder Ludwig, *Church and State*, 1999. Conference of the Ordinaries of Tanganyika Territory, *Conference of the Ordinaries of Tanganyika Territory, Kilapapala Seminary 1958 [proceedings of the]*, 1958, p.18.
[45] PA Widmer Documents re Evangelizzazione e opere per lo sviluppo: Edgar Maranta, *Letter to Mario, DSM 04.07.1959*.
[46] Eugene CSSP Hillmann, *Missionary approach to pagans*, in African Ecclesiastical Review, 1959, p. 8.
[47] Edgar Maranta, *The Catholic African and the Present Social Evolution in Africa*, 1953; Edgar Maranta, *Social Evolution in Africa*, in Worldmission, 1954; Edgar Maranta, *The Catholic African and the Present Social Evolution in Africa*, in African Ecclesiastical Review, 1959.

mission vicariates became local churches.[48] The Catholic Church started to make new African Bishops, too, but the heads of the Dioceses were still the European mission bishops like Maranta.[49]

Implicitly speaking, from the position of a Catholic Church based in nations that had not been recent colonial powers in Africa (the Swiss, the Dutch, and the Irish were mentioned), there was no question in Maranta's mind that the "era of overseas colonies is very quickly nearing its end." He added: "this is as it should be."[50] In his speech, Maranta was more concerned with a Christian imprint on the new state than with nation building as a process that would integrate Tanganyikans of diverse religions and turned its back on the colonial past. He acknowledged African experiences of colonialism, although as a step to Christianization.

> "colonial people will of course be more inclined to remember the hardships and injustices they have suffered at the hands of the colonizers [… ] Catholic Africans should not be blind to the great material and moral progress realized in Africa through the intermediary of colonial powers [who] may have had very different aims than spreading the Gospel, [and still] they were but tools in the hands of God!"[51]

In this text, Maranta spoke to the educated Catholic African who were "called upon to co-operate in shaping this new and rapidly growing Africa, and above all to help saving this soul of Africa [which was about to be] drawn into the vortex of so-called progress", the progress of atheistic materialism, as the Pope called it in an encyclical some years later.[52] Maranta's text asserted the right of nations to self-determination, and the equality of races, but it poses the Church, rather than only its Tanganyikan African members, as the crucial institution for the future of the nation. Maranta's proposition was not only one of multiracialism, but also an explicitly transnational one. It was a transnationalism steeped in a conservative, spiritual and paternalist world. Certainly, the Africans were "better able to speak for their own country and to stand up for their interests", but the way Maranta presented his case did not take African knowledge or experience into account as a base for the new nation.

In the end, what Maranta proposed was that the Catholic African should not take an anti-colonialist position. He felt the Catholic role should be more to spread the moral teachings of the faith and to defend the role of the Catholic social thinking. Catholics should defend Church institutions and powers in the field of social and educational life against secularizing tendencies which wanted to limit the Church to the sacristy. On the basis of Christian morality, Maranta

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[48] PADSM 20/Mahenge Diocese 20 History: Callistus Mdai, *Diocese of Mahenge: Sketchy Notes on the History of the Diocese*.

[49] One of about 20 new African Bishops in the period 1951-58 in Africa according to Maxwell was an offspring of the Capuchin mission: Bishop Elias Mchonde. See chapter 9. But this could not cover up that the missions had missed, or hat not had the time, to train a local clergy in time. David Maxwell, *Decolonization*, 2005, p. 292; John Stuart, *British Missionaries and the End of Empire*, 2011, p. 16; Marita Haller-Dirr, *The Capuchin Order in Tanzania*, in San Damiano. Newsletter of Franciscan Capuchin Friars of the Province of Tanzania, 2007; Marita Haller-Dirr, *Afrikanisierung*, in Ite, 2011. *Aus den Missionen*, in Providentia, 1956.

[50] This was quite certainly an active move in defense against the critique of the missionary imperialist, for a more explicit statement see: *Komm herüber und hilf uns!*, in Missionsbote der Schweizer Kapuziner in Afrika, 1955.

[51] Edgar Maranta, *The Catholic African and the Present Social Evolution in Africa*, in African Ecclesiastical Review, 1959, pp. 232-233.

[52] Papst Pius XII., *Fidei Donum. On the Present Condition of the Catholic Missions, Especially in Africa* (1957).

argued that mediation rather than revolution was the role of the Christian. Strong institutions could reinforce the stability of the Church in a decolonizing world. Maranta consequently prepared the ground. He had been active in creating the institutions the African Catholics were to defend and which they could use to build an independent state.

## The Situation in Ulanga

In 1952 P. Hieronymus Schildknecht, the head of the Ifakara mission station, described the changes he had seen in Ifakara, since he had first come to this place in 1932. At that time - Schildknecht reminded his readership - Ifakara had been a typical village in the bush, with not much more than a post office signboard attached to a half-derelict African hut and some tin boxes which served half a dozen of shops ran by Indian trader families. But in the early 1950s, a new post office had taken pride of place, along with a large market to which the Mission had contributed the tiles, flanked by a government school and the mosque used by the 20 Indian families now trading in Ifakara. The bush land had been cleared for new brick houses and where a mango tree grove had stood. Now, a rice mill refined two or three thousand tons of this rather expensive agricultural produce, mainly for export out of the district. In addition, on the outskirts of Ifakara about 200 tons of sugar was produced annually. Ifakara was still a quiet place in general, "the world that fills tranquility with noise and that transforms leisureliness into hurry has not yet conquered Ifakara", Hieronymus' Capuchin colleague Meinhard Inauen wrote. Yet it was Ifakara which was the place for 130,000 people living in Ulanga that served as the gateway to the world[53]: to places of work, education and amusements.[54] Ifakara was clearly a place where the modernization of the political and social coalesced.

### Development hopes

In the initial post-War years, the colonial administration had expressed great hopes for Ulanga: "the tremendous potential agricultural wealth of Ulanga is still largely untapped," the District Officer who succeeded A.T. Culwick felt in 1946, but "with the scheme for the development of the Kilombero valley and that of Ulanga Rural Development both included in the ten year development plan for the territory, there should be a great future in store for the District."[55] In the 1950s and 1960s these long-cherished hopes of Ulanga becoming an important asset for the Territory seemed to have been realized.[56] At first, development in Ulanga meant

[53] Mlango, the Kiswahili term for 'door' also means gateway or opening in the sense of describing the mouth of a river Erich Eberle, *Kiswahili (2nd edition)*, 1953, p. 108. Kamusi online dictionary: http://kamusi.org/define?headword=mlango&to_language=371, last accessed 28.4.2014.
[54] P. Meinhard Inauen, *Ifakara - das Tor zur Welt*, in Missionsbote der Schweizer Kapuziner in Afrika, 1957.
[55] TNA 461/27/1: Tanganyika Territory District Commissioner Mahenge et al., *Annual Report Ulanga District 1946*; Lukas Meier, *Striving for Excellence*, 2012, pp. 49-53, 133.
[56] C. Gillman, *South-West Tanganyika Territory*, in The Geographical Journal, 1927; TNA 461/27/1: Tanganyika Territory District Commissioner Mahenge et al., *Annual Report Ulanga District 1946*.

something much smaller than the great groundnut scheme. The first post-War development schemes for Ulanga had failed in the late 1940s even before they could take off. In 1954, under the heading 'Development Plans', the District's Annual Report mentioned a market for indigenous beer that had been built in Ifakara, a courthouse in Chera, and in Mahenge a kiln for the manufacture of bricks, as well as a large house where clerks could be housed when they brought messages from the peripheral Native Authorities – hardly an extensive rural development programme.[57]

But then, in the mid 1950s, hopes for the arrival of the railway were rekindled and sugar was turned into a major export by the establishment of a large plantation. "The year 1955 may be the turning point in Ulanga District," wrote the District Commissioner. The Mission was convinced, too, that "in the long run, Tanganyika cannot afford the luxury of neglecting the best of its agricultural land. Earlier or later large-scale agricultural use of the Kilombero plain *must* (italics in original) happen."[58] Yet, administrators brought little specialized expertise for 'development'. They were still jacks of all trades in matters such as agriculture, forestry, fauna conservation, animal husbandry, or health care.[59] The administration exerted much pressure on local farmers to produce for the market and progress – it was said – was not for free, it would have to be "achieved, not merely by asking, but only by working for it."[60]

At the moment of independence "it seem[ed] likely", an article on the Kilombero valley concluded, "that the Kilombero valley will play an important role in the future economic development of Tanganyika".[61] Major development projects in the Kilombero were planned or realized during the first two decades of independence.[62] The establishment of *Kilombero Sugar* plantation and factory brought a substantial change in the form of agricultural production in the valley. Kilombero Sugar took a new approach, different from the small-scale cash-crop production favored by earlier colonial development for Ulanga. Kilombero Sugar was financed partly with money from the Colonial Welfare and Development Fund, imported 'Dutch' expertise from Java and established a large-scale plantation project on (at that time) at least 25,000 acres

[57] TNA 461/27/1: Tanganyika Territory District Commissioner Mahenge et al., *Annual Report Ulanga District 1954 [15.12.1954]*.
[58] P. Hilmar Pfenniger, *Ulangaebene und Ifakara*, in Missionsbote der Schweizer Kapuziner in Afrika, 1957. A.D. Beck, *Kilombero Valley*, in East African Geographical Review, 1964.
[59] Michael Longford, *Flags Changed at Midnight*, 2001, p. 339.
[60] TNA 461/V2/1: C.F. Beauclerk et al., *Letter to P.C. E.P. 05.07.1955*. This pressure continued into independence: R. Jätzold et al., *Kilombero Valley*, 1968, pp. 52n20, 60.
[61] A.D. Beck, *Kilombero Valley*, in East African Geographical Review, 1964.
[62] Rather unrealistic were the plans drafted by the FAO based on large scale irrigation schemes, although some of it was eventually implemented by a German project Lukas Meier, *Striving for Excellence*, 2012, pp. 133-134. A second major development project was the railway. It reached Mikumi from Kilosa in 1960 and in 1963-67 it was extended to Kidatu where it could serve the sugar plantation. Rolf Hofmeier, *Transport and Economic Development*, 1973, p. 7; Rudolf Peter Mayombo, *Economic structural changes and population migration in Kilombero Valley*, 1990, p.6. It reached Ifakara on a different line in the 1970s, when TAZARA, the "freedom railway", was being built with major support by the Chinese. As Monson shows the railway would bring 'Ujamaa' into Kilombero in a complex way, pushing villagization, but also – rather indirectly – empowering farmers to create their own modernization, to develop new regimes of labour, production and commerce: Jamie Monson, *Maisha*, 2003; Jamie Monson, *Defending the People's Railway*, in Africa, 2006; Jamie Monson, *Africa's Freedom Railway*, 2009.

of land, with the same amount reserved for future development.[63] It also 'modernized' African small-scale production by including a sizeable amount of so-called "out-growing", hoping that about 1,000 African "investors" would contribute to the overall production of the sugar factory.[64] Additionally, it was linked to a new agenda behind villagization and soon brought a large number of migrant workers to the valley.[65] It seems that Ulanga indeed became, in the course of the 1960s, a much more important producer of cash crops and a major exporter of agricultural produce and at the same time attracted new people – a reversal of earlier trends.[66] Missionaries presented Kilombero Sugar as an example for the role of the Mission as fostering progress. It was only possible because of the contribution of masons, mechanics and secretaries, who had learnt their trades as students at the mission schools, that 3,000 workers and 30 scientists and engineers would soon produce 35,000 tons of sugar annually.[67]

## Political change

In contrast to the initial post-War years, when food-shortages were a major problem, the early 1950s in Ulanga were "good years" in the eyes of the colonial administrators. Food was plentiful and the agricultural produce of the district gained record prices.[68] Yet this did not assure a quiet labour force. Lorne Larson has shown a wide range of protest movements under way in Ulanga in the late 1940s and in the 1950s. Although the large-scale industrial action in Dar es Salaam in 1947 had not spread to in Ulanga, a long line of 'unorganized' strikes, for example in the Rice and Cotton factory in Ifakara (Vithaldas Haridas & Co) and in many mission stations took place in Ulanga from the late 1940s. In 1957 trade unionism really came to Ulanga, and to Ifakara in particular, with organized strikes that had support from supraregional unions.[69] There was also a bit of direct aggression against missionary staff in the 1950s. Nina Disler told the story of the missionaries in Ifakara being verbally abused in the road as "Fresssäcke" (which probably translates best as "gluttons".[70]

[63] TNA 461/V2/1: *Kilombero Sugar Company Limited [12.10.1960]*. The Dutch seem to have 'taken over' from South Africans who were not coming to Kilombero, as the mission reported: P. Hilmar Pfenniger, *Ulangaebene und Ifakara*, in Missionsbote der Schweizer Kapuziner in Afrika, 1957. In 1954 Siegwart reported about the original plans for a South African investment of 70'000 acres, equalling 283 square kilometres: Ladislaus Siegwart, *Die Arbeitsteilung bei den Pogoro*, 1954, p. 66.
[64] A.D. Beck, *Kilombero Valley*, in East African Geographical Review, 1964.
[65] Rudolf Peter Mayombo, *Economic structural changes and population migration in Kilombero Valley*, 1990.
[66] Eckhard Baum, *Land Use in the Kilombero Valley*, 1968, pp. 44ff; Hans Ruthenbrand, *Agricultural Development in Tanganyika*, 1964, n.p.: maps showing agricultural production in 1957. compare this with Rolf Hofmeier, *Transport and Economic Development*, 1973, table p. 30/30.
[67] Walbert Bühlmann, *Afrika*, 1963, p. 53.
[68] TNA 461/27/1: Tanganyika Territory District Commissioner Mahenge et al., *Annual Report Ulanga District 1947*; TNA 461/27/1: Tanganyika Territory District Commissioner Mahenge et al., *Annual Report Ulanga District 1951 [08.01.1952]*.
[69] TNA 461/27/1: Tanganyika Territory District Commissioner Mahenge, *Annual Report Ulanga District 1957 [06.01.1958]*; Lorne Larson, *History of Mahenge*, 1976, pp. 362-364. Lukas Meier cites from to term "strike-mania" from the diary of Thierry Freyvogel who spent these years at the Swiss Tropcial Institute Field Laboratory. Lukas Meier, *Striving for Excellence*, 2012, p. 113.
[70] Franziska Löpfe, *Auf sich gestellt*, 2007, p. 69.

At the same time, the power of the chiefs was giving way to a broader political spectrum. 'Beni' dance societies witnessed a renewed wave of popularity. Beni dances, with brass band music and military drill and ranking, had been popular in the 1920s in Mahenge.[71] In the post-WWII phase, a modernized and globalised musical knowledge was transported back into Ulanga by young men and 'danzi/dansi', ballroom-style dancing to largely Jazz-inspired music became a "craze", Larson writes, throughout Ulanga district.[72] Rolf Diethelm, who worked in Ifakara in 1959 as a doctor made a recording which shows not only the musical style but also the explicit national twist such musical tradition had taken by then: the "TANU Youth League Jazz Band" played the sound of the cosmopolitan African town in Ifakara.[73] In a situation of growing class differentiation, dansi was a much used platform for debates about respectability (*heshima*), moral behaviour and, not least, about alternative perspectives and sources of modernity. Nationalist aspirants challenged chiefs and presented, in writing, alternative tribal histories alongside modern concepts of citizenship.[74]

Government reformed local administration with the creation of local and tribal councils, which often used the language of social welfare and development, as James Giblin has argued for neighbouring Njombe District.[75] In 1954, the colonial administration formed a new Ulanga District Council to meet twice a year.[76] In 1956 it was suggested by this council that Ifakara should be raised to Township status.[77] In September 1957 Chief Hassani Njohole died after a long and severe illness. The missionaries and Sr. Arnolda were invited as guests to his funeral.[78] Njohole's nephew, Ahamadi Mahawanga, was elected "by a large majority" as his successor.[79] Mahawanga was to be the Chief who saw the transition to independence. He too seems to have fused regional pride with a debate on development, for example in his welcome speech to the Governor in 1960: "We are also obliged to express our thanks to you for enabling us to have piped water supply here in Ifakara, and for improving our roads though they are still not very good [...and] present you with this gift, an axe, a spear and a shield as reminders of the Umbunga tribal weapons.[80]

In Ulanga, not only the authorities in charge of Indirect Rule, but 'Europeans' in general had begun to be criticized in local debates. Lorne Larson presents an interesting example with

[71] Lorne Larson, *History of Mahenge*, 1976, pp. 321-322.
[72] Lorne Larson, *History of Mahenge*, 1976, pp. 331-333; Maria Suriano, *Letters to the Editor and Poems*, in Africa Today. The conservative missionaries regretted that Catholic teachers, who possessed gramophones were playing 'European' music for dances bringing together male and female dancers in close movement: Ladislaus Siegwart, *Die Arbeitsteilung bei den Pogoro*, 1954, p. 179.
[73] PA Diethelm Rolf Diethelm, *sound recording and title list*.
[74] Jamie Monson, *Claims to History*, in The International Journal of African Historical Studies, 2000; Lorne Larson, *History of Mahenge*, 1976, pp. 339-341.
[75] Lorne Larson, *History of Mahenge*, 1976, pp. 345-346; James Giblin, *Divided Patriarchs*, 2000, p. 182.
[76] TNA 461/27/1: Tanganyika Territory District Commissioner Mahenge et al., *Annual Report Ulanga District 1954 [15.12.1954]*.
[77] TNA 461/27/1: Tanganyika Territory District Commissioner Mahenge, *Annual Report Ulanga District 1956 [06.01.1957]*.
[78] PADSM 153/4: Hieronymus Schildknecht, *Jahresbericht Ifakara 1957*.
[79] TNA 461/V2/1: Tanganyika Territory District Commissioner Mahenge, *Letter to P.C. E.P. 17.11.1958*; TNA 461/27/1: Tanganyika Territory District Commissioner Mahenge, *Annual Report Ulanga District 1957 [06.01.1958]*.
[80] TNA 461/V2/1: Chief Ahamadi Mahawanga et al., *Welcoming speech of Chief Ahamadi Mahwanga, of Ifakara*.

an extract from a farmer's diary in 1955: European rule was unwanted and extracted labour with no gain to the African. The Europeans who had arrived poor now were "rich and fat".[81] They needed to present themselves in the best light, which was, often, their long tradition of practical assistance to the social development of Ulanga. In the course of the 1950s the mission in Ifakara began to feel the effect of political change. Political Officers' reports also described "a considerable awakening of interest in political and Trade Union matters [...] Trade Unionism has taken a firm hold, particularly in Ifakara and such matters as wage rates and conditions of service are being subjected to searching criticism."[82] The missions were themselves victims of the strikes, but they also feared those who left mission tutelage and challenged the missions. These "defectors", as Lorne Larson calls them, were often the most promising Catholic-trained individuals. Christian male heads of families travelled for work as masons, teachers, police, postal or train services, and even for work in hospitals outside Ulanga. P. Hieronymus Schildknecht, head of the mission in Ifakara, counted those absent and complained that particularly the young soldiers returned with money, and talked about life in the town. This fired student boys and girls in mission schools to challenge teachers and nuns." [83] One of the defectors was Peter Mgohakamwali, who had been head teacher in Ifakara, a prestigious mission post, but left in 1943 for Dar es Salaam.[84] Mgohakamwali returned to Ifakara in about 1947 and was, in the eyes of the Mission, probably a 'troublemaker'. For example, he was a leading figure in the African Association in Ifakara.[85] The African Association had formed in Ulanga around a nucleus in Ifakara in about 1945 and started to make broad political claims and demanded social services.[86] The Association was initiated by former mission teachers, but soon it was a mouthpiece of commercial interests as well, and was strongly supported by the local Muslim elite. Thus, the Association voiced, for example, traders' interests in Ifakara in 1947.

## Demand for a Hospital in Ulanga

Health care was one of the fields in which political claims for development and welfare were made. The African Association now joined the demands for medical services in Ifakara.

[81] Lorne Larson, *History of Mahenge*, 1976, pp. 366-367. The farmer is Ramadhani Willibald Ligonja, one of the early generation of Christians, who had later converted to Islam.
[82] TNA 461/27/1: Tanganyika Territory District Commissioner Mahenge, *Annual Report Ulanga District 1957 [06.01.1958]*. I have interviewed a group of men in Ifakara, most of them former clerks, who remembered with warm nostalgia how they were energized by the political movements that formed into TANU. Focus Group 5, 12.05.2010 Ifakara. FGD done with the assistance of Phemy Muhaku.
[83] PADSM 153/4: Hieronymus Schildknecht, *Jahresbericht Ifakara 1955*. Ulanga Christians migrated for labor so much that P. practiced itinerant pastoral work in the 1950s again: Pater Fridolin Fischli, *Missions-Diaspora*, in Missionsbote der Schweizer Kapuziner in Afrika, 1950. Teachers, who often hosted danzi-events in the 1950s are thus the most striking example showing how the mission as a cultural and social movement (which consisted of much more than the missionaries only) had contribute to create the class of people who was now claiming rights to go along with modernity. Lorne Larson, *History of Mahenge*, 1976, pp. 333, 335.
[84] Lorne Larson, *History of Mahenge*, 1976, pp. 319-320.
[85] Lorne Larson, *History of Mahenge*, 1976, p. 353.
[86] This section draws its information from: Lorne Larson, *History of Mahenge*, 1976, pp. 352-361; John Iliffe, *Modern History of Tanganyika*, 1979, chapter 13.

Since 1946 Ifakara had a Native Authority Dispensary, located not far from Sr. Arnolda's 'hospital'. Hopes for a transfer of the Hospital Assistant from Kiberege to Ifakara had quickly been shattered.[87] Hence, Chief Hassani of Ifakara was not happy with the quality of staff available for the dispensary.[88] In mid-1947 explicit demands about medical services in Ifakara came up again, not unlike those which we have discussed in a previous chapter.[89] The "Asian" community, with support of the Ulanga planters and the African Association in Ifakara, lodged a petition for a "Mass Meeting" about medical services with the Medical department.[90] In the petition for better medical services in Ifakara, it was laid out that:

> "the population has to suffer for lack of Medical Service and facilities. [...] There are no doubt so called Government dispensaries at Kiberege and Ifakara but these are lacking in supply of medicines except a little bit of material for dressings and are staffed with very low paid African dressers who are neither qualified medical men nor can be helpful in cases of any kind of illness.
>
> [...] Glaring reports of all kinds of amenities provided to the public may appear on paper and the outside world may be induced to believe that the population althroughout [sic] the country is made happier by authorities governing the Territory but no one can honestly say that, notwithstanding continuous complains, anything has been done for the human population of Ulanga District.
>
> We do not think any higher medical authority has ever visited or gone into the matter of taking action for prevention of such diseases such as malaria, influenza etc., which are largely prevalent in the District or even given a meager consideration to provide satisfactory medical amenities to the suffering humanity of Ulanga which it is entitled to in this twentieth century when the medical service has far advanced. It will not be wrong for us to say, with all due respect, that while adequate medical care and services are provided in jails for criminals, the peaceful civilian population of the largest Township has been entirely neglected by the Medical Department.
>
> Any excuse such as shortage of qualified staff cannot [unreadable] stand ground since the war is over for last two years and if qualified medical officers cannot be brought from outside for the time being arrangements can easily be made to get qualified men from Uganda.
>
> In conclusion we urge that immediate attention should be given to establish a proper dispensary and hospital at Ifakara staffed with a qualified medical officer and necessary assistant and nurses to alleviate sufferings of the population [...]."[91]

The Director of Medical Services, P.A.T. Sneath, did not feel he was in a position to help. In the midst of policy struggles about the quality of rural health care, he was not willing to give way to "the public desire to 'flog' Government and its vulnerable departments." He felt that it was better to

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[87] TNA 461 16/19: Tanganyika Territory District Officer Mahenge, *Letter to District Commissioner E.P. 19.08.1946*; TNA 461 16/19: Tanganyika Territory Provincial Commissioner E.P., *Letter to DC Ulanga. 14.09.1946*.

[88] TNA 461 16/8 Vol I: Hassani Njohole, *Letter to DC Mahenge. Ifakara 10.01.1947*.

[89] See earlier discussion about health services in Ifakara in chapter 2 and in particular the discussion of a letter of "K. Truth" in the Tanganyikan Standard. TNA 61/231H: R.R. Scott, *Letter Dir. of Med.Services to Chief Sec.: "Hospital Ifakara". DSM, 29.01.1941*.

[90] TNA 450/653: Indian Association Ifakara et al., *Letter to Dir. of Med.Serv. DSM, District Comm. Mahenge and Provincial Comm. E.P. DSM. Ifakara, Ulanga District 09.06.1947*. Petitions were a widely used means of speaking about African grievances to the colonial political powers using the language of moral reasoning: Chima J. Korieh, *May It Please Your Honour*, in History in Africa.

[91] TNA 450/653: Indian Association Ifakara et al., *Letter to Dir. of Med.Serv. DSM, District Comm. Mahenge and Provincial Comm. E.P. DSM. Ifakara, Ulanga District 09.06.1947*.

> "divert the direction of their thinking to how they can help themselves with governmental assistance [...] I am strongly of the opinion that the ultimate solution of our medical problems must be found from the concern of local authorities in finding their own answer [...]."

Instead of offering concrete assistance to what can be said to have been a very specific demand by the petitioners of Ifakara, Sneath chose to make a general point about local administrators who made Africans feel that they were entitled to medical services as a "free gift".[92] The Provincial Commissioner replied by making a concrete suggestion: the newly erected N.A. dispensary with burnt brick walls and cement floor (though it only had a thatched roof) should be handed over to the Medical Department. Ifakara could also serve Kiberege; and Mahenge Hospital could supervise the medical work done in Ifakara.[93] In January 1948, in another mass meeting, the petition was repeated, this time "under the auspices of the African Association".[94] The Provincial Commissioner, who voiced his sympathy with the demands, now pushed again for action to be taken laid and he seems to have received support from the Chief Secretariat.[95] Yet Sneath himself remained steadfast in his stance that "the time [was] not yet ripe for such expansion of the medical service" and opposed even a simple transfer of a Hospital Assistant from Mchangani to Ifakara.[96] A suggestion came up again, not unlike the ones we have seen it in the 1930s and the early 1940s: "It is noted that there is a mission where a good many of the sick attend. Is there no possibility of enlarging the scope of this for the benefit of the inhabitants of Ifakara?"[97]

## Alternatives and competition among institutions of modernization

From what we have seen above, many of the inhabitants of Ifakara would not have wished to invest in mission medical services. On the contrary, the local demand for state services must be read as a sign of distrust of the Catholic mission. The Muslim presence was strong, and in 1953 the priests in Ifakara wished to have splendid and loud bells to chime from a new church in this "Islamic centre".[98] At least the missionaries could count, to some degree, on the support of the Sultan in Ifakara, Hassani Njohole (Njoholi in German-language sources).[99] Hassani - "no

[92] TNA 450/653: P.A.T Sneath, *Letter Dir. of Med.Serv to Chief Sec. DSM, 07.07.1947*.
[93] TNA 450/653: Tanganyika Territory Provincial Commissioner E.P., *Letter to Dir. of Med.Serv to 16.08.1947*.
[94] TNA 450/653: African Association Ulanga Branch Ifakara et al., *Letter to Chief Secretary, Dir. of Med.Serv. DSM, District Comm. Mahenge and Provincial Comm. E.P. DSM. Ifakara, 02.02.1948*.
[95] TNA 450/653: Tanganyika Territory Provincial Commissioner E.P. et al., *Letter for Prov. Comm E.P to Chief Sec. DSM 21.02.1948*; TNA 450/653: Tanganyika Territory Chief Secretary to the Government, *Letter to Dir. of Med.Serv. DSM 01.03.1948*.
[96] TNA 450/653: I Laufer, *Letter Medical Officer to Distr. Comm. Mahenge. Mahenge 31.07.1948*; TNA 450/653: Tanganyika Territory Director of Medical Services et al., *Letter to MO Mahenge. DSM 06.09.1948*. What happened instead was that Dr. Laufer, who seems to have supported the extension, was transferred away from Ulanga in November the same year, much to the regret of the political officers: TNA 461/27/1: Tanganyika Territory District Commissioner Mahenge et al., *Annual Report Ulanga District 1948*.
[97] TNA 450/653: Tanganyika Territory Director of Medical Services et al., *Letter to MO Mahenge. DSM 06.09.1948*.
[98] *Erzbischof Edgar Maranta*, in Missionsbote der Schweizer Kapuziner in Afrika, 1953.
[99] Hassani himself was said to rule the Wambunga of Ifakara since 1914, when he had been a young man. In 1939 he was awarded the "King's Medal for African Chiefs", the highest award for an African chief. E. K. Lumley, *Forgotten Mandate*,

dynamic personality, but sober and righteous and just", in the eyes of a District Officer; literate, but "not very well educated" according to the P. Hieronymus – had been friendly towards the Mission, and had assisted the missionary in the 1930s and during the war.[100] Not least, in the eyes of the Mission, the Chief had given a hand to the control of Protestant encroachment in Ifakara.[101] Whether the relationship really had been that friendly all the time is a matter of doubt[102], but the way Njohole was presented by P. Hieronymus in the 1950s attests to a good standing between chief and mission at that particular time.[103]

These other religious groups were offering alternative ways of living to the Catholic one. In the mid-1950s Ifakara was believed to have about 12,000 inhabitants, of whom just under a third was Catholic, and 5,000 were Muslim, the rest being “heathen”, or "in a very small number" Protestant. [104] By the end of the 1950s the official census showed 14,000 inhabitants already, of whom 4,500 were Catholic and 8,800 Muslim.[105] The Catholic Church was also nervous about the presence of other sects of Christianity, and the District Officer Michael Longford witnessed a kind of low-intensity war between Danish Lutheran and Catholic missionaries in the late 1950s.[106]

Thus, the Catholic Mission was not only challenged by general nationalist sentiment or the feelings of well-trained, upwardly mobile respectable people. It also felt pressure from Muslim modernity, as well as from traditionalists, and from other Christian groups, who started to enter the field of modern medical services. In 1949, the Danish Lutheran Church started a 'hospital' in Kipingo, in the Malinyi area, probably headed by a nurse.[107] When the original buildings were demolished in a flood, the hospital was rebuilt in a place called Lugala.[108] Although the Danish Lutherans had only two mission stations in Ulanga at the time, they

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1976, p. 123. By 1948 Ifakara had grown so much, that the Colonial administration appointed an additional "subordinate Native Authority". The "new man" had already been a Nduna (an advisor, sub-chief) at Ifakara and had assisted Hassani without full Native Authority powers. Old and unhealthy Hassani at that time seems to have caved in to the pressure of the administrators to raise his subordinate: TNA 461/27/1: Tanganyika Territory District Commissioner Mahenge et al., *Annual Report Ulanga District 1948*. Ramazani Kiwanga had been on the District officer's wish-list for a long time: TNA 461/27/1: Tanganyika Territory District Commissioner Ulanga et al., *Kiberege Division -Ulanga District Annual Report 1941*. The Njohole family was also in control of Native Authority in Lupiro, on the other side of the Kilombero riverflood valley. TNA 461/27/1: Tanganyika Territory District Commissioner Mahenge et al., *Annual Report Ulanga District 1953 [31.12.1953]*. Interview with the Njohole family members, May 2010.

[100] E. K. Lumley, *Forgotten Mandate*, 1976, p. 122; Pater Hieronymus Schildknecht, *Sultan Hasani und die Mission Ifakara*, in Missionsbote der Schweizer Kapuziner in Afrika, 1952.

[101] PADSM 153/4: Hieronymus Schildknecht, *Jahresbericht Ifakara 1952*. Inauen confirmed the good relations between Hieronymus Schildknecht and Njohole, but he also explained that the authority of the Chief was limited and some of his Ndunas had a better standing with the population: *Interview with P. Meinhard Inauen, Dar es Salaam, 28.01.2009*.

[102] For example in 1949 Njohole pressed even the Christians to attend the witchcraft eradiction procedures of Songo. DAK & PA Dreier Lorne Larson, *Witchcraft eradiction [manuscript]*, p. 32. On Njohole's distanced take on the Europeans see also: E. K. Lumley, *Forgotten Mandate*, 1976, p. 122.

[103] Victorian Beytrison, *Vergib uns unsere Schulden*, in Missionsbote der Schweizer Kapuziner in Afrika, 1954. Jamie Monson, *Tribal Past*, 2005, p. 111.

[104] Afrika Mission der Schweizer Kapuziner, *Jahresbericht der Schweizer Kapuziner in Ost-Afrika*, 1956.

[105] PADSM Box 153: *Chronica V [Capuchin Mission Ifakara]*, entry for 12.07.1959.

[106] Michael Longford, *Flags Changed at Midnight*, 2001, p. 304, 306 On the history of protestant presence in Kilombero see Marcia Wright, *German Missions*, 1971, pp. 151ff , p. 192; F. R. Hansen, *Mission, Church and Tradition*, 2004.

[107] TNA 468 / 28/19 vol I: C.F. Beauclerk, *Letter DC Mahenge to Miss A.B. Frederiksen, Kipingo Mission, P.O.Ifakara. 11.09.1951*.

[108] SolidarMed et al., *Assessment Lugala Lutheran Hospital*, 2008, pp. 7-8.

invested considerably in the medical establishment. At the end of 1958, Nurse M.K. Christensen was registered for Lugala, where Dr. Sorensen already practiced, or had recently started to practice.[109]

This move in the region of the Catholic mission stations of Sofi and Mtimbira made the Swiss missionaries very nervous. "I have just received a letter from Sofi," a Capuchin priest reported in 1957, "that we must undertake something, else the Protestants are coming."[110] Probably even Edgar Maranta felt that the Lutheran activity in Malinyi (Lugala) was a "serious danger in this area richly populated by Christians." Extending medical services there was thus a priority of the Bishop.[111] Sofi had been an important but contested station for a long time. Sleeping Sickness control activities added yet another complication, to which the Mission reacted by upgrading its medical services as well, so that the Mission could claim to have health issues under control.[112]

Modern traditionalists also made an impact in the area at the time. Witchcraft cleansing movements were always present in Ulanga (and the Mission was up in arms against these activities).[113] One of the most vibrant moments was when "Songo" came to Ifakara in 1949. Coming in from Dar es Salaam, Amri bin Mawkela, who was the person behind the movement drew large crowds, including the large majority of the local Catholics, who seem to have been under pressure to attend these public witchcraft cleansing ceremonies.[114] In Ifakara Songo included a powerful modern performance, executing elements of modernity but most probably bringing them into a 'traditional' moral context.[115] Those who attended his ceremonies to be 'shaved' were received by a Karani, who took down the identity of the person in writing. Then those who attended were placed in a row and their hair was shaved, before everyone was 'injected' or vaccinated with a liquid on both sides of their temples, their hands, and feet. Afterwards, everyone took back a small quantity of 'medicine' in a bottle with him/her. Even in a trading town like Ifakara, this quickly led to an acute shortage of bottles. The Mission sent out

[109] TNA 450/1177: *[file] Registration of Nurses*; TNA 461/27/1: Tanganyika Territory District Commissioner Mahenge, *Annual Report Ulanga District 1957 [06.01.1958]*.
[110] DAK folder 'parishes various shauris': P. Vincent *Letter to P. Generalvikar. Mtimbira, 15.05.1957*. Hieronymus Schildknecht in Ifakara also acted swiftly against 'protestant encroachments': *Interview with P. Meinhard Inauen, Dar es Salaam, 28.01.2009*.
[111] *Unsere Missionsschwestern*, in Providentia, 1958; *Interview with P. Meinhard Inauen, Dar es Salaam, 28.01.2009*.
[112] PADSM 208/2: P.Peter Anton, *Quartalberichte Sofi: August&Sept. 1943; April-June 1944; April-Juni 1945; Januar-März 1947; Jahres-Bericht Sofi 1944*; TNA 61/104/H/4: A. T. Culwick, *Letter DO Mahenge to PC E.P. 14.01.1944*; PADSM 208/2: P.Peter Anton, *Jahres-Bericht Sofi 1944*; PADSM 208/2: *Besprechung über die Sofi Siedlung [Kwiro 05.01.1947]*; DAK folder 'parishes various shauris': Pater Fridolin Fischli, *Letter to P. Gerard and P. Generalvikar. Sofi, 03.12.1957*; DAK folder 'parishes various shauris': Pater Fridolin Fischli, *Letter to P. Gerard. Sofi, 13.12.1957*. Soon Mtimbira would get a strong dispensary where sisters were continuously posted from February 1959, and continued to work there even when it was transferred to Government, as a health centre in the early 1970s. Sr. Consolata Kaufmann, *Mtimbiras erste Krankenschwester erzählt*, in Missionsbote der Schweizer Kapuziner in Afrika, 1960; ASML R2T1S2blauO2 Afrika. Tanzania.../Mtimbira, Sofi: Sr. M. Josefata Schürmann, *Letter to H. Güntert. Health Centre Mtimbira, 08.01.1975*; *Unsere Missionsschwestern*, in Providentia, 1958.
[113] TNA 61/128 vol II: Edgar Maranta, *Letter to PC E.P. DSM nd [arrived 09.03.1943]*.
[114] DAK & PA Dreier Lorne Larson, *Witchcraft eradiction [manuscript]*, p. 34.
[115] James Giblin, *Precolonial Politics*, 1996; Steven Feierman, *Peasant Intellectuals*, 1990. On anti-witchcraft movements in the 1940s in relation to Sleeping Sickness resettlements see chapter 4.

one of their African members who found that it was in this manner that Songo successfully treated fevers and other kinds of indisposition with a medicine that consisted of "quinine, paludrin and other anti-malaria medication which his aides had bought in large amounts in all the shops in Ifakara, and which was, probably, mixed with some herbs."[116]

## The services of the Modern health care sector in Ulanga in the 1950s

At the end of the 1940s, nine sleeping sickness dispensaries were run in Ulanga with money from the Colonial Development and Welfare Funds.[117] These dispensaries were clean and in excellent repair, the District Commissioner reported, and all maintained fruit orchards for the benefit of their patients.[118] Another set of 10 dispensaries was run by the Native Authorities, including the dispensary at Ifakara.[119] Attendance numbers for Native Authority (N.A.) dispensaries in 1954 seem to indicate that by that time, men still attended slightly more often than women did.[120] With an estimated population of about 130,000 people living in the district, a total of 233,000 attendances at N.A. dispensaries were registered, of which 60,000 were 'first attendances'. If those numbers were counted correctly, which they were not always, almost half of the population would have attended a dispensary once during a year in the early 1950s. Even if counted incorrectly, the numbers show that a substantial section of the population used N.A. dispensaries. When one adds attendances counted at missions, then the coverage was even higher. Whatever the amount of mis-recording, the numbers also indicate that the majority of those attending the dispensaries used these services repeatedly, if not regularly. A special case was the dispensary at Mtimbira which had, with a total of 25,000, by far the highest number of attendances of all N.A. dispensaries, with only an average number of first attendances. Well over 90 per cent of attendances by women in Mtimbira were re-attendances, and this shows that a well-run dispensary could reach a great number of users relying on their services.[121] Another characteristic of the numbers at Mtimbira was the low ratio of male attendance with only just about a third of the total, a situation unlike any other place in Ulanga. With almost 20,000 attendances, the N.A. dispensary at Ifakara was third in terms of size in the district, and falls in

[116] Zu Songo: Oswin Baumann, *Songo*, in Missionsbote der Schweizer Kapuziner in Afrika, 1950. On the role of techno-scientific objects in Tanganyika see also: Eleanor Fisher et al., *Spectacle of Modernity*, 2000. This manner of using anti-malaria medication was not too unusual, it seems. See for example: Pascal James Imperato, *Bwana doctor*, 1967, p. 48.

[117] There had been much discussion and anxiety in the district that these services would collapse if not paid for by the Colonial Welfare and Development Fund, see: TNA 461/27/1: Tanganyika Territory District Commissioner Mahenge et al., *Annual Report Ulanga District 1947*.

[118] TNA 461/27/1: Tanganyika Territory District Commissioner Mahenge et al., *Annual Report Ulanga District 1948*.

[119] TNA 461/27/1: Tanganyika Territory District Commissioner Mahenge, *Annual Report Ulanga District 1949 [31.12.1949]*.

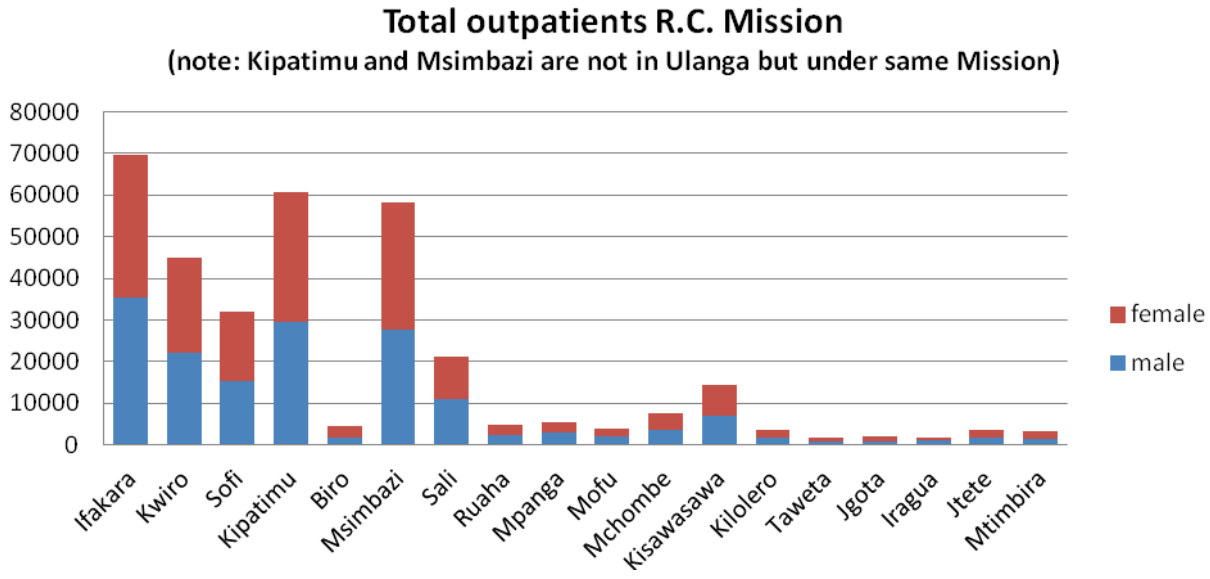
[120] See chapter 3. The analysis in this section draws on: TNA 461/27/1: Tanganyika Territory District Commissioner Mahenge et al., *Annual Report Ulanga District 1954 [15.12.1954]*. TNA 450/1563/3: *Annual Report Eastern Medical Region, 1954 [statistics]*.

[121] For a discussion of contemporary service quality and the usage of facilities in the region see: Lucy Gilson et al., *Community Satisfaction*, in Social Science and Medicine, 1994; Karin Gross, *Intermittent Preventive Treatment*, 2012; Angel Dillip, *Gaining Access*, 2012.

line with the general picture we get of the usage of dispensaries run by the Native Authorities in the district at the time.

Compared to the government services, missions had smaller numbers of first attendances. But with almost 70,000 attendances in its largest dispensary in Ifakara, mission dispensary services precisely matched the total number in the NA sector.[122]

***Graph: Outpatients***[123]




By 1958, female attendance at N.A. dispensaries in Ulanga district had slightly overtaken male use in total. This was also the case in the mission dispensaries in Sofi, Kwiro and Sali which were 'grant-earning' because they had registered nurses in charge. It was not, however, the case in an urbanizing space like the Msimbazi mission dispensary outside Dar es Salaam, where almost two-thirds of the outpatients were men. Unlike in 1954, in 1958 the Ifakara hospital's outpatient practice tilted the gender scale for the entire grant-earning mission sector. With more men using mission outpatient services in Ifakara now, overall the Mission looked after more men than women. A male bias was particularly accentuated in hospital care. In the new mission hospital in Ifakara 60 per cent of in-patients were male. In the government hospitals in Mahenge and Morogoro, the ratios were even slightly more biased towards male use.

## Tanzanian Medical Policies since WWII and the Place for Missions

The medical services available in Ulanga were located within the framework of postwar medical policies in Tanganyika. R.R. Scott's successor as head of the medical administration in

[122] The number must be read with caution: it would mean that well over 200 consultations were held every day – and also that a person from Ifakara would have to visit the Dispensary at least five times a year. An explanation might be that the Mission dispensaries serves as outlets of drugs, and that drugs were often not given to patients for consumption at the dispensary rather than to take them home.

[123] Compiled from: TNA 450/1563/3: *Annual Report Eastern Medical Region, 1954 [statistics]*.

the Territory in the post-War years, Paul Andrew Turner Sneath, was new to the colony. Sneath eventually wore himself out in a struggle to make medical standards and preventive services prevail over political considerations in the rural, dispensary-based, health service.[124] In Sneath's era, the extension of health care services, and even preventive ones, in rural areas, like Ulanga, did not keep pace with the needs to appease rising demands by rural consumers, politicians and administrators - while hospital services in cities were given priority.[125]

In an environment in which (medical) development came to be seen as something that needed to be financed from development funds and thus partly independently from a colonial territory's financial ability, Sneath wanted more community contribution:

> "If the health of the public in its most inclusive sense is, in fact, ' a people's war' money is not our greatest need, nor, indeed, is imported manpower. The materialistic attitude of construction and manning medical establishments and dispensing medical services to a passive or indifferent people can do little more than mislead and pauperize the beneficiaries. Our concern must be to show the need, demonstrate the solutions, and expect the participation of the people in the practical solution of what are manifestly their own local government problems."[126]

Participation would also mean that Africans could be charged fees. The political officers were not in entirely in favour of this change. Some felt that "the only advantage the Africans get from their tax is that of a dispensary and nothing else."[127] As was to be expected, the payment of fees for a service hitherto free of charge will be generally unpopular", the District Commissioner wrote from Mahenge. [128]

Notwithstanding many dissonances in policy development, it was during Sneath's era that the foundations for rural health care for the time into the era of independence were laid. In 1949, E.D. Pridie, the chief medical advisor to the Colonial Office, was invited to draw up a plan for the medical development which was cast into a report.[129] The report suggested to establish a system of rural health centres, to diversify the dispensary system into two grades, and to implement new training schemes, for example one for rural midwives (on the lines of the one which had already been implemented in the Sudan). A note on Rural Health Care in the Dar es Salaam Medical Administration shows that the ideal in the early 1950s was to establish rural

[124] John Iliffe, *East African Doctors*, 1998, p. 45; Ann Beck, *Medicine, Tradition, and Development*, 1981, pp. 11-13; Walter Bruchhausen, *Medizin zwischen den Welten*, 2006, p. 115; Patrick Thomas Malloy, *Holding by the Sindano*, 2003, pp. 207, 213-218; Denise Roth Allen, *Managing Motherhood*, 2002, 29-32; Oswald Masebo, *Society, State and Infant Welfare*, 2010, pp. 211-222.

[125] TNA 450/653: Tanganyika Territory Director of Medical Services et al., *Letter to MO Mahenge. DSM 06.09.1948*. Tanganyika Territory Medical Department, *Annual report of the Medical Department for the year ended 31st December 1948*, 1950, 7, reporting on Pridie Committee. suchen Tanganyika Territory Director of Medical Services, *Memorandum on the Post-War Development of the Tanganyika Medical Services*; Gerardus Maria van Etten, *Rural Health Development in Tanzania*, 1976, p. 36.

[126] Sneath quoted in: W.J.M. Evans, *Survey of a Tropical Area*, in The Journal of the Royal Society for the Promotion of Health, 1950, p. 455.

[127] TNA 61/ 351 Vol II: Tanganyika Territory District Commissioner Morogoro, *Letter to P.C. E.P. 14.11.1950*.

[128] TNA 61/ 351 Vol II: Tanganyika Territory District Commissioner Mahenge-Ulanga, *Letter to P.C.E.P.Mahenge, 10.11.1950*. Some Native Authorities in Ulanga believed that fees could be raised, could keep those away who came for medical treatment without reason, and that the income produced from fees could help in the provision of drugs. TNA 61/ 351 Vol II: Tanganyika Territory District Commissioner Kilosa, *Letter to P.C.E.P.Mahenge, 02.11.1950*.

[129] Tanganyika Territory, *Report of the Rural Medical Services Committee*, in Sessional Paper No 6 of 1948, 1948.

medical stations that had both curative and preventive medicine staff, mostly African, which would be "trained on more modern lines than heretofore".[130] The institutional core of the vision of rural health care development was the Health Centre, which would be "responsible for ensuring the highest standards of health in the community". The health centre was meant to include midwives undertaking domiciliary work, African health visitors and health inspectors all "instilling the value" of good environmental sanitation and hygiene in the local community, and fostering "village health committees", and was conceptually (over)burdened with public health work.

> "Broadly speaking the main emphasis should be placed on the provision and protection of water supplies, [...] refuse disposal [...] measures against disease carrying insects; improved housing [...] soil conservation and improved agricultural method; provision of adequate child health clinics; ante natal facilities; [...] and ideally the curative and preventive aspects of medicine should go on pari passu."[131]

The use of the word "ideally" shows that the person writing here was well aware that the people still demanded injections rather than Native Authority initiatives to implement refuse disposal measures.[132] With demand growing, the political administration felt that government was not even capable of "holding the present position" in delivering health care to the rural population.[133]

For Sneath, it was "really imperative", nevertheless, that no new dispensaries should be established: "the expansion of the dispensary service should keep step, not only with the availability of trained staff, but with the capacity of district medical staff to supervise the work."[134] At the same time as the health centre was hailed as the locus of rural development, medical standards were prioritized over the claims which were born from social and political change. Under these circumstances, it is little surprising that there were openings for missions to enter the scene of medical services in rural areas. There was popular demand, which political officers wanted to see appeased, but the Medical Department spent two thirds of "Development and Welfare Plan" money for the erection of just two hospitals in the larger cities, leaving little

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[130] TNA 61/ 351 Vol I: Tanganyika Territory Medical Department, *Circular letter no 1398/69, 23.08.1948*. TNA 13350 Vol III: *Note on "Rural Health Services"*. The plans for health centres were continued into the next plans *A Plan for the Development of Medical Services in Tanganyika With Special Reference to the Period 1956/1961*, 1956[?], pp. 1, 5.

[131] TNA 13350 Vol III: *Note on "Rural Health Services"*. Note that the idea of the health centre was not new: Der DMSS wrote in his ‚Memorandum of Medical Policy, DSM 1938, p8, hier pp.12: „The dispensary must become a health centre […] The preventive outlook must at all costs be inculcated into the dispenser and dresser, although his first duties are curative.”TNA 455/692/: Secretary Missionary Committee, *Memorandum by the Medical Committee of the Tanganyika Missionary Council on the levying of fees in mission dispensaries by persons not qualified as a Medical Practitioner*.

[132] *A Plan for the Development of Medical Services in Tanganyika With Special Reference to the Period 1956/1961*, 1956[?], p.2. Response to such demands was conceived of as an issue of 'democratic' structures TNA 61/ 351 Vol II: Tanganyika Territory District Commissioner Rufiji, *Letter to P.C. E.P., 27.06.1951*.

[133] TNA 13350 Vol III: E.G. Rowe, *Memorandum No. 5 for the P.C's Conference, June 1953: The need for a medical and rural health service plan*. More than 400 rural dispensaries were in place at the time. TNA 13350 Vol III: *Note on "Rural Health Services"*.

[134] TNA 13350 Vol III: N. Chilton, *Comments of Dir.of Medical Services re Memorandum No.5 for the Provincial Commissioners' Conference, June 1953 by Rowe, PC NP, 25.06.1953*. The Provincial Commissioners were little impressed with the arguments by the Medical administration: TNA 13350 Vol III: Tanganyika Territory Conference of Provincial Commissioners, *Extract from minutes of Conference in 06.1953*.

for rural services.[135] Missions could bring in better-trained staff, and 'hiring' missions through grants-in-aid schemes would still not unsettle the health centre policy to which the medical administration had subscribed. Notwithstanding the closer cooperation of government and mission through the system of grants-in-aid, mission services in Ulanga would develop into a hospital centred system, rather than make substantial investments into a sort of health centres.

## Grants in Aid System and the Mission Hospital

A grants-in-aid system towards mission medical services had started in the late 1920's with grants being paid for leprosy work and, in some cases, mother and child health care services.[136] The Capuchin mission received support towards its leprosy work from these coffers. After World War II, grants were paid to missions towards their medical staff who did general curative and preventive work. However, missions did not feel that their contribution was valued enough by Government.[137] When in 1953 new regulations for grants-in-aid were to come into place Bishop Maranta complained in the name of the Tanganyikan Bishops conference that most Catholic mission were not prepared for a change in the system. Under the proposed scheme grants to mission dispensaries were to be paid for by Local Authorities and central government was to concentrate on fully medicalised institutions, "approved hospitals and leprosaria having a resident medical practitioner in charge".[138] The missions faced the threat that 'mission hospitals' which were not 'hospitals' in the government sense, in that they had beds but were not regular clinics with qualified doctors at the centre of medical work, would be financially dependent on meagre local government resources. At this point, the Catholic Missions formed their own Medical Mission Committee. It was intended to coordinate the efforts of the Catholic missions in matters relating to grants, but it also worked to coordinate Catholic mission medical activities into some sort of consistent policy.[139] Thus, the committee served as a voice to represent the Catholic Bishops in the pursuit of a policy of investment in the quality of mission medical

[135] Tanganyika Territory, *Revised Development and Welfare Plan for Tanganyika, 1950-1956*, 1951; Walter Bruchhausen, *Medizin zwischen den Welten*, 2006, p. 121. This hardly changed much from 1956, when the plan explicitly mentioned the hospital sector: *A Plan for the Development of Medical Services in Tanganyika With Special Reference to the Period 1956/1961*, 1956[?], pp. 2, 17.
[136] T. W. J. Schulpen, *Integration of Church and Government Services*, 1975, pp. 80-89. He presents a detailed chronology of grant regulations. Michael Jennings, *Matter of Vital Importance*, 2006; Michael Jennings, *Healing of Bodies, Salvation of Souls*, in Journal of Religion in Africa, 2008.
[137] Ann Beck, *History of British Medical Administration in East Africa*, 1999 [1970], p. 168-169. She draws on a letter of Bishop Maranta dated 106.102.1952.
[138] TNA 13350 Vol III: Stowell[?], *Letter 1283/1/583 Dir of MS to MSS re: Grants in Aid to Medical Missions Rural medical Units*.
[139] PAL Sch 1061.3 Ärzte etc. Verschiedenes: Catholic Medical Mission Comittee, *Minutes of the first meeting. Kurasini 05.01.1953*; T. W. J. Schulpen, *Integration of Church and Government Services*, 1975, pp. 75-79. For some time the committee even was named to be a 'grant committee'.

services.[140] The missions throughout the 1950s pressed the government to raise the grants-in-aid.[141]

Indeed, in 1955, new regulations made grants towards hospital beds possible (before that, payments were made according to the number of trained staff in an institution). The missions remained in a precarious position with fears that Government would "assume responsibility for all medical care."[142] The years 1955 to 1959 have been described as the anti-climax of government-mission cooperation in medical matters.[143] Yet it was exactly at that time (between 1953 and 1959) that the main sections of St. Francis hospital in Ifakara were built, and with it many other Church hospitals in Tanganyika.

## Catholic hospital politics

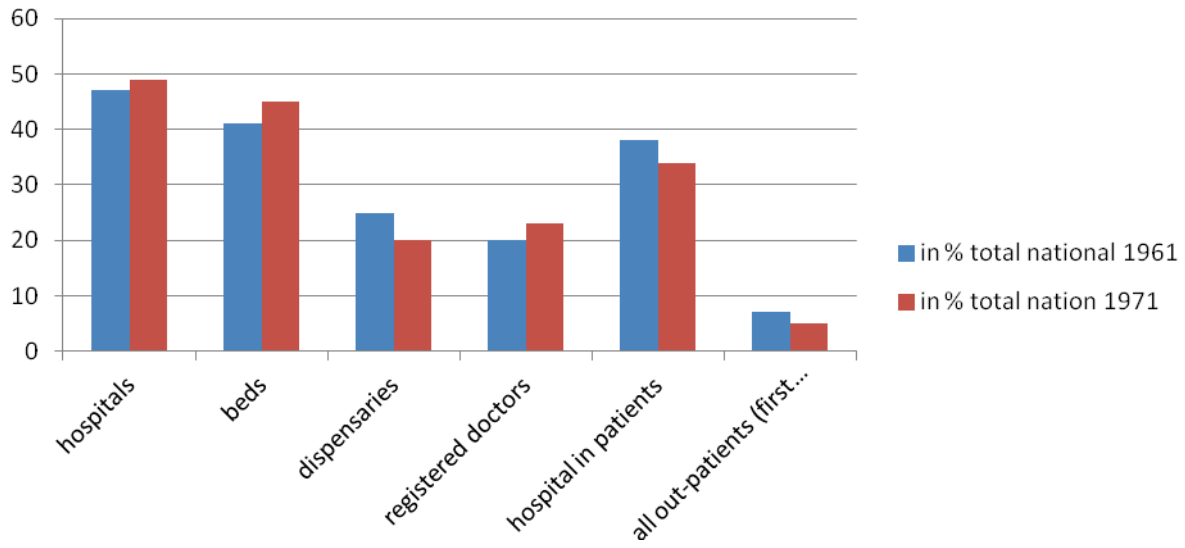
In 1954, "a Catholic doctor in the field" described the state of Catholic mission medicine in Tanganyika. Catholic missions had entered later than Protestant missions and still only had half as many doctors as the number in non-Catholic missions (12 in Catholic versus 25 in non-Catholic hospitals).[144] The author of the memorandum felt that government politics were giving priority to "the needs of mushroom towns and artificially developing settlements, i.e. the administrative centers" while rural services – and some of the major Catholic places – remained neglected. Still, there was, according to the memorandum, a clear-cut Church policy that every Vicariate should have a hospital that was "well built, strategically placed and adequately staffed." The hospital was not meant to work autonomously, but as "the focal point in any medical system which we may establish, the centre from which dispensaries and other services should radiate into the distant village." There was therefore a policy to build an entire system, with a biomedicalized hospital and with dispensaries, which should, according to this mission doctor, "become more naturally parts of the tribal institutions."

The growth of missionary services, in general, or the Catholic sector more specifically, in the years 1946-1960 cannot be established here in detail. Schulpen's and Van Etten's research indicate a "considerable" increase in the number of mission hospitals in the late 1950s, particularly on the Roman Catholic side and notwithstanding the critical period of the grants-in-

[140] PAL Sch 1061.3 Ärzte etc. Verschiedenes: Catholic Medical Mission Comittee, *Minutes of the first meeting. Kurasini 05.01.1953*.
[141] TNA 692/1 Missions-Policy: Tanganyika Territory Mission Medical Committee, *Letter to Director of MS. DSM 30.09.1955*.
[142] TNA 692/1 Missions-Policy: Ray. L. Cunningham, *Letter and Memorandum Chairman of Luthern Missions Council to Direct. of MS. Lushoto 18.02.1957*.
[143] T. W. J. Schulpen, *Integration of Church and Government Services*, 1975, pp. 114. Sivalon's chronology on broader social services provision by the church presents a very different view with "years of harmony" from 1953-66, followed by "tense years" (1966-76) and a "reemergence of the church as a major service provider" afterwards: John C. Sivalon, *Roman Catholicism*, 1990; John C. Sivalon, *Catholic Church and Tanzanian State*, 1995.
[144] PAL Sch 1061.3 Ärzte etc. Verschiedenes: *Impressions of the present state of mission medical services in Tanganyika and suggestions regarding their future development by a Catholic doctor in the field*. All quotes in this paragraph from this source.

aid cooperation.[145] Another analyst of Tanganyikan health services shows that the mission share of hospital beds and doctors rose from a third in 1946 to 41 per cent and was even as much as 45 per cent of the total number of hospital beds in 1961 and 1971 respectively.[146] These numbers give no geographical information. With a substantial number of government hospital services concentrated in the major towns, certainly the ratios in rural areas must have looked even more favourable for mission medical services. To reach these numbers, considerable investment by the missions into new hospitals and wards was necessary.

***Graph: Proportion of mission service in % of the total health services in Tanganyika/Tanzania[147]***




Ifakara is an example for the way in which Catholic hospital politics and changes in the grant scheme contributed to the conglomerate of factors that made building a mission hospital attractive. While the Mission struggled to get its nurses registered, having a trained medical doctor in Ifakara was most imperative to receive central government grants for medical work. Given the local political situation and because there was a government dispensary in Ifakara already, it was unlikely that the local Authorities would pay a huge sum for the mission medical work literally just around the corner. It is likely, that Bishop Maranta felt that for this and also for other reasons of competition, the changes in the grant regulations meant that he had to either take the giant leap needed to set up a full hospital, or lose the Mission's position – and the

[145] Gerardus Maria van Etten, *Rural Health Development in Tanzania*, 1976, p. 37. Schulpen enquired the founding year from all mission hospitals in Tanganyika. Indeed his numbers seem to indicate that never was there a period of fasterd growth than in the years 1950-1960. T. W. J. Schulpen, *Integration of Church and Government Services*, 1975, p.101, table 106.107 on p.128. The mission propagandist booklet of Zucchelli tries to show a sort of golden age of mission medicine, but his numbers are not very clear: Severino Zucchelli, *Medical development in Tanganyika*, 1963, pp. 49-54.
[146] Oscar Gish, *Planning the Health Sector*, 1975, pp. 180.
[147] Oscar Gish, *Planning the Health Sector*, 1975, table 13.

grants-in-aid – in health care. A hospital was the definite reason to employ a medical doctor but the presence of a doctor was also a prerequisite to receive good grants from central government towards the mission dispensaries in Ulanga at least for some time in the forseeable future.[148] Additionally, there was a chance to access a prime position in health care in the District: the concept of a designated district hospital was present in the source cited above.[149] With a clear vision, Maranta might have seen the path towards these designated district hospitals, a position he tried to secure for the St. Francis Hospital in about 1963 and which the hospital in Ifakara would eventually assume in 1976.[150] At first, however, with missions having invested in expensive-to-run hospitals the missions were not satisfied with what Government considered a "substantial" rise of grants-in-aid to Missions in the early 1960s.[151]

## Conclusion

For the Capuchin mission, there were many reasons why a hospital was a clever answer to the late colonial situation. Some 30 years into the Mission's presence in Ulanga, and in a time of social and political unrest and change on the global and local stage, Ifakara had become the place to act. The Mission considered that "from a missionary point of view, Ifakara takes prime position in Ulanga-District," and it was meant in the largest sense, as Ifakara had become a major hub where multiple dimensions of social change were voiced.[152]

Ifakara now had the potential to be the centre of an area of about 130,000 people of which probably 50,000 were Catholics and the Mission had a stable base there: the Mission owned a large plot of land in the midst of a place which was designated for multiracial settlement. Three European priests, four brothers, seven sisters and two lay nurses all from Switzerland worked in Ifakara in 1953, and 2,000 individuals in the population had been born with assistance of Sr. Arnolda.[153] In the eyes of the missionaries, "organic" growth was possible in Ifakara, because it

[148] See list attached to: TNA 13350 Vol III: Stowell[?], *Letter 1283/1/583 Dir of MS to MSS re: Grants in Aid to Medical Missions Rural medical Units*.

[149] Hospitals which "are in effect functioning as district hospitals in the absence of a Government hospital or [which] by agreement with Government are doing specific work which would otherwise have to be done by the Government medical services." TNA 13350 Vol III: Stowell[?], *Letter 1283/1/583 Dir of MS to MSS re: Grants in Aid to Medical Missions Rural medical Units*.

[150] Certainly there was a discourse within missions about the de facto district hospital position of some of their hospitals: TNA 450/1283/14: Barclay Leechman, *Memorandum no. 177 for Standing Finance Committee: Subsidisation of certain mission hospitals, 07.09.1953*; TNA 450/1283/14: *Letter to M.J.Phillips, UMCA Minaki. 14.10.1953*; TNA 450/1283/14: *Letter to C.F.Taylor, Mkomaindo Hospital. 14.10.1953*.

[151] TNA 450/HE1636: Tanganyika Territory Ministry of Health et al., *Report to HE the Governor [work of MoH during 1959]*. Cf. D.E. Fergusons hypothesis that grants were given by government in order to support the 'conservative' influence of the missions: D.E. Ferguson, *Politcal Economy of Health and Medicine*, 1980, p. 337. Leader Stirling, *Africa: my surgery*, 1987, pp. 148-153.

[152] Afrika Mission der Schweizer Kapuziner, *Jahresbericht der Schweizer Kapuziner in Ost-Afrika*, 1953; A. Brantschen, *Die ethnographische Literatur über den Ulanga-Distrikt*, in Acta Tropica, 1953, p. 164.

[153] P. Hilmar Pfenniger, *Ulangaebene und Ifakara*, in Missionsbote der Schweizer Kapuziner in Afrika, 1957; *Eine Missionsschwester erzählt*, in Jahresbericht der Schweizer Kapuziner in Afrika 1951, 1951, p. 27; TNA 461/17/4: C.F. Beauclerk et al., *Letter to Statistician i/c DSM. Mahenge, 17.10.1951*; Afrika Mission der Schweizer Kapuziner, *Jahresbericht der Schweizer Kapuziner in Ost-Afrika*, 1953. It also had quite large-scale agricultural production in Ifakara.

was blessed with the steady presence of "the same priest, the same brother in charge of building, the same sister in charge of the sick."[154]

For decades, the Mission had promoted the idea that a hospital, more than a church or a school, could reach the place where the African soul was most vulnerable: in the moment of sickness and frailty. It was a prime tool of intervention as a process that touched both the body and the soul and was able to steer social change more than in just material matters. A hospital fell quite naturally into the new missionary purpose as a shepherd of African modernization into the new era. The floodgate symbol which we have witnessed with Culwick was applied to the new hospital as well: Ifakara was the 'door' to the world, the Mission wrote when it presented the new hospital to the readers in Switzerland, and:

> "one may regret the fact that this door has opened [...] but who could shut a door, which the mass is pouring through. It cannot be the missionary's task. Ours is to attach the cross above this door."[155]

As we shall see in the next chapter, it was to be a large and "lavish" cross.[156] The Mission chose to establish a beacon of modernity as the tool with which to counter modernity. In an article signed by Karl Schöpf, the doctor and designer of the hospital in Ifakara, but probably authored by a missionary propagandist, the Mission presented a huge area ("as big as Denmark") where a large population ("as many inhabitants as the city of Basel") was in need of adequate health care. The hospital constituted a medical vision for the modernization of Ulanga. Electricity, piped water, X-ray equipment and the laboratory, all these things were "weapons against the terrible diseases that threatened the marrow of this people", and would help to educate the African in cleanliness, prevention, sensible nutrition. These modern virtues would take the place "of the many useless things the African likes to buy for his small money."[157]

Hospital services were a symbol for the benefit of the local Catholic and non-Catholic alike that Christianity played a role in the future of the nation, not only in the religious but also in the secular dimension. In a society that had become highly complex and where the idea of a dichotomous world of 'modern civilization/primitive', and 'state/tribe' as the foundation of colonial governance had become undermined, a large, modern hospital in a rural setting was an institution that could cater for a wide range of demands and anchor the Catholic Church in Tanganyika. At the same time, as we shall see in chapter 9, a functioning hospital also served to inspire support at home in Switzerland during a time of change. The Mission was also at the helm of the new road the Africans took towards the future, as a new nation in the process of development but "within a global network Franciscan love." St. Francis was made the patron for

*Interview with Franz Solan Mathis, Luzern, 16.12.2010*. In 1944 the mission planted 30 acres of rice and produced 38 tons of rice. P. Gallus Steiner, *50 Jahre Mission Ifakara*, in Missionsbote der Schweizer Kapuziner in Afrika, 1962.

[154] P. Meinhard Inauen, *Ifakara - das Tor zur Welt*, in Missionsbote der Schweizer Kapuziner in Afrika, 1957.

[155] P. Meinhard Inauen, *Ifakara - das Tor zur Welt*, in Missionsbote der Schweizer Kapuziner in Afrika, 1957, p. 134.

[156] P. Hilmar Pfenniger, *Ulangaebene und Ifakara*, in Missionsbote der Schweizer Kapuziner in Afrika, 1957. *Interview with P. Meinhard Inauen, Dar es Salaam, 28.01.2009*.

[157] Karl Schöpf, *Das Spital von Ifakara*, in Missionsbote der Schweizer Kapuziner in Afrika, 1957. Schöpf, when shown the actual article in an interview in 2007, could not remember ever having written this piece.

this new development.[158] Yet, as much as the decision for a hospital followed the kinetics of the historical situation, it also unleashed a new institution, a powerful, large and ambitious one with a life of its own.

[158] PAL Sch 1060.5: P.G.W., *Ein Missionsspital [Newspaper cutting, unknown newspaper, maybe Vaterland]*.


"Mission Hospital of St. Francis", ca 1953 with patients, nun nurse N.N. and "lay-helpers" Franca Gulotti (left) and Sophie Kaufmann (later: Sr. Sara, on the right)[1]

Ifakara: The old hospital building, ca 1950

[1] [from *Die Schweizer Kapuziner in Afrika. Jahresbericht 1953*, 1953.]

Out-patient work in the 1950s. A visitor wrote: "Here sits enthroned the the dignified Baldegg sister, behind a mountain of drugs, which are being dispensed to the people who defile past."[2]
The nurse actually dispensing probably is Susana Ngomaholo

The new all new St. Francis Mission Hospital, 1957.

[2] E.M. Zimmermann, *Impressionen von einer Ostafrikareise. 1. Folge*, in Tam-Tam, 1965.

# Chapter 8 The Late Colonial Period of a Mission Hospital

Saint Francis Hospital in Ifakara traces its organizational structures back to the early 1950s. Sister Arnolda had already worked in what the mission considered a 'hospital' in Ifakara. Her 'hospital' was indeed quite substantial both as a building and in terms of the number of patients it treated. It was a nursing home for the elderly, a node for modern birth practices, it offered in-patient accommodation, and a well arranged assortment of drugs and dressings (chapter 5). However, within a couple of years after the arrival of the first doctor in Ifakara in 1951, the meaning of 'hospital' in Ifakara changed substantially. As had been the case in Mahenge when the Drs. Gabathuler had come to take over Mission medicine, the doctors in Ifakara transformed 'dispensary' work into clinical work based on the organizational patterns of the modern hospital. The most explicit change was that surgery (beyond what was called minor surgery, i.e. the suturing of wounds) entered medical practice in Ifakara. Within a couple of years, the word 'hospital' came to mean a shiny whitewashed and large building complex, new technical equipment (especially the X-Ray[1]), a rapidly increasing number of professional staff from overseas as well as local places, a male doctor in a surgeon's coat (and in tennis clothes in his spare time), and a multi-racial set of patients. All this must have changed the way people looked upon medicine in Ifakara.

While the Mission Hospital 'celebrated' modernist medicine in Ifakara, it also established a discourse of rapid catching up with modernity from humble beginnings in a 'stable'. Even before new buildings were established, the new beginning was marked with a new name, Mission Hospital of St. Francis.[2] These changes stood on firm institutional ground. For reasons

[1] *Interviews with Edgar Widmer, Thalwil, 23.10.2008 und 27.10.2008*. Note however that in 1959 there were about 711 X-ray's done, plus 873 X-rays of the lungs, i.e. not more than 6 X-rays day Anonym, *Auch Zahlen können sprechen*, in Jahresbericht, 1960.

[2] On 24.06.1951 it was given the new name according to: PADSM 153/5: Hieronymus Schildknecht, *Vorgeschichte zur Gründung der Mission Ifakara*. See the section with images between chapters 7 and 8 and note that the public name was in

described in chapter seven, the mission was prepared to make a substantial investment in medical services in Ifakara. Between 1950 and 1951, the mission tripled expenses for supplies, quadrupled expenses for staff, and made an all-new investment into hospital buildings in Kipatimu and Ifakara.[3] With the St. Francis Hospital in the process of growth, the mission recruited new professionals for its medical arm and concentrated most of this medical staff in Ifakara. A new generation of nurses from Baldegg came to Ifakara from the early 1950s and was supplemented with nurses from a laic Catholic background, also recruited in Switzerland. Doctors, too, were no longer the "mission doctors" of the old school. Nonetheless, Bishop Edgar Maranta lent his full support to the Austrian Dr. Karl Schöpf, who eventually stayed in Ifakara until the late 1960s and is remembered as *Dr. Calo* to this day in Ifakara, as the founder of the St. Francis Hospital together with Sr. Arnolda.[4] All these changes meant that the Hospital was really established as an institution in the Swiss Capuchin Mission in East Africa. And when the Government looked upon Ifakara's medical mission work with new eyes from the later part of the 1950s, St. Francis Hospital became the central institution in the provision of health care in Ulanga.[5]

This chapter presents the history of the St. Francis Hospital up to the mid 1960s in three parts. The first section is concerned with the history of the hospital as it was developed as an institution. It was at this time that the basic institutional structures were created. We will see how a new hospital was built and how this linked to the presence of a surgeon and the politics hinging on the position of the Church in the nation of the future. In the second part, we look at the practice of medicine in the hospital. We look at the staff working at the hospital, the relations between different categories of health workers, and of those between health workers and patients. These relations were rather more 'late colonial' than 'post colonial'. In the third part, we look at the Tuberculosis (TB) section at the St. Francis Hospital in order to explain the late colonial modernization in terms of medical services. It was committed to bring fully modernized hospital services to Ifakara, and presented to the people a medicine that was both technical and difficult to sustain.

English then, the language of state medicine rather than the typical language for the mission, which was Kiswahili and (Swiss) German.

[3] TNA Acc.450/HE/178/16: P. Hilmar Pfenniger, *Financial Report 1950*. TNA Acc.450/HE/178/16: Edgar Maranta, *Letter to Direct. of MS, DSM 14.08.1952*. On Kipatimu see: TNA 450/1501/6: *[statistics for Kipatimu Mission medical treatments], Kwiro, 09.03.1951*; Institutsarchiv Baldegg BIII,6,4: *Chronik Kipatimu*; *Unsere Missionsschwestern*, in Providentia, 1959.

[4] Focus Group Interviews in Ifakara, May 2010.

[5] TNA 450/1614/10A: Tanganyika Territory Provincial Medical Officer E.P., *Medical Department. Eastern Province. Annual Report 1958*; TNA reading room copy: *Eastern Province Annual Report 1960*.

## Unstable Beginnings

In May 1951, Dr. Walter Müller arrived in Ifakara and under his guidance medical work in Ifakara was reorganized. For the first time in many years, P. Hieronymus (and not much later Sr. Arnolda, too) went on home furlough in the early 1950s, and when he returned to Ifakara he found that the "mission hospital" had contributed to the good standing of the Catholic mission in Ifakara.[6] Müller had turned, it was said, an old building, "a stable", from the 1920s into a hospital, with an X-Ray machine, a sterilizer and a theatre.[7] Müller was not going to stay for long, though. To Bishop Maranta the reasons for Müller's desire to return were not entirely clear, and he suspected Müller's wife was to blame.[8] Müller found the conditions in Ifakara unfavourable for his medical work and his operations in the 'stable' tended to fail.[9] In October 1952 Müller returned to Switzerland and the Mission had to report, that "a hopeful beginning for a well-developed mission hospital has been stalled – but not terminated."[10] That the Mission did not take Müller's withdrawal as a sign that the unhappy experience of the mission with hospital medicine from Mahenge was about to be repeated shows the growing determination of the mission to invest in medicine,.

Müller's withdrawal had seriously injured the income the Capuchins could expect from government grants. With the new doctor in service, Bishop Maranta tried to get a larger, 'hospital' grant from the medical administration and the medical administration promised a substantial grant to Bishop Maranta for the medical work of the Roman Catholic Church in Ulanga.[11] Maranta struggled to get his accounting consistent with the way government offices wanted to see it. There had already been withdrawals of earlier grants for nurses in the Capuchin mission, because their medical credentials and their actual postings were not easily established.[12] These grants, in any case, covered only the smaller part of the mission's

[6] PADSM Box 153 Ifakara Mission and Parish 4: Hieronymus Schildknecht, *Ifakara 1953*.
[7] It remains unclear to us whether he did, in fact, work mostly from Sr. Arnoldas' purpose built 'maternity' buildings from 1937. TNA 461/27/1: Tanganyika Territory District Commissioner Mahenge et al., *Annual Report Ulanga District 1951 [08.01.1952]*; PAL 1061.4: Adelheid Schuster, *Letter to E. Maranta. Kwiro 09.06.1951*. Schöpf remembers that he was afraid the sterilizer would blow during one of the first operations he did as a successor of Müller. Interview 2008. There is a bit of a myth around the 'stable'. At Schöpfs departure in the late 1960s, the mission journal noted that Schöpf had made the hospital from what originally had been a stable for cows into a modern hospital: N.N., *Abschied von Chefarzt Dr. C. Schöpf*, in Ite, 1969. Schöpf, and also Diethelm, likened the original buildings indeed to a European stable in order to explain what the original buildings were like. In an interview with me, both Schöpf and his wife Irmengard, explained that there had been many medical institutions at the time housed in 'stable-like' buildings. PA Diethelm Rolf Diethelm, *Tagebuch*, entry for 28.06.1959; Karl Schöpf, *Daktari Kalo erzählt*, 1997; Heinz Janisch, *[Radio broadcast] Menschenbilder: Irmengard und Karl Schöpf: Zuhause in Tirol und Afrika*, (2007). *Interviews with Karl and Irmengard Schöpf, Zams 23-25.07. 2007*.
[8] PAL Sch 1061.6: Edgar Maranta, *Letter to C.Schöpf. DSM, 28.08.1952*.
[9] Interview with P. Meinrad Inauen, Dar es Salaam, 2008/9
[10] PADSM Box 153 Ifakara Mission and Parish 4: *Quartalbericht Ifakara (August – Dezember 1952)*.
[11] TNA Acc.450/HE/178/16: R.E. Barrett, *Letter to Director of Audit, Colonial Audit Dept. DSM, 09.04.1951 re Grants in Aid to Missions*. Later Maranta tried to get higher contributions from government sources as there was a change in the grants-scheme under way which was meant to make Native Authorities responsible for grants towards dispensaries. TNA 450/1283/13: S. A. Walden, *Letter PC E.P. to Member for Local Government at the Secretariat. Morogoro, 15.09.1953*. For 1954 Sofi and Sali were recommended for a N.A. grant: TNA 450/1283/13: *Letter Regional MO to DMSS. Morogoro 26.04.1952*; TNA 450/1283/16: *Minutes of the third meeting of the mission medical advisory commitee, held at Medical Headquarters DSM. 14.07.1955*.
[12] TNA Acc.450/HE/178/16: P. Hilmar Pfenniger, *Letter to Direct. of MS, DSM 19.04.1951*; PAL 1061.4: Adelheid Schuster, *Letter to P. NN. Kwiro 04.08.1953*.

investment in the recurring expenditure of the hospital at the time.[13] However, the medical administration heavily criticized health institutions in Maranta's diocese in 1952 and, in early 1953, pressure was put on Maranta to "remedy the defects in Ifakara".[14] The Bishop was told that the medical administration had "good reason to believe that the building and facilities [in Ifakara] are not yet up to anything like an adequate standard for a general hospital."[15] And, as in the mean time the hospital had been deprived of its doctor, the officer in charge could not at all promise any grants being paid, even when the "excellent Maternity Centre" was taken into account.[16] The grants were not immediately only because the administration wanted to "enable a mission to take steps to remedy any matter which have led to a recommendation for withdrawal."[17] Maranta understood the hint and immediately asked for "plans of the kind of hospital which would be suitable for Ifakara", and explained that he was soon going to have a new doctor in Ifakara:

> "As regards the hospital at Ifakara we are doing our best to improve conditions and we intend to build a proper hospital there, but it will of course take some time. In any case I cannot make definite plans for the new building before Dr. Schoepf arrives and tells us what his wishes are."[18]

Indeed, the missionaries in Ifakara knew that Maranta already engaged in talks with a prospective doctor, Karl Schöpf from Austria. While the Mission waited for the new doctor, well-trained nurses – Catholic, but not members of an order – arrived from Switzerland in order to assist Sr. Arnolda.[19] By the end of 1953, Ifakara hospital was under the new medical director. Despite this, the report on Ifakara drafted by the Medical officer from Mahenge hospital, Butler, led to the withdrawal of the grant for 1954.[20]

[13] For 1952 Maranta reported that the grants covered the smallest chunk (about 11%) of the cost, outnumbered even by patient fees (about 13%). The rest, just over three quarters was paid for by the mission. TNA Acc.450/HE/178/16: Edgar Maranta, *Letter to Direct. of MS, DSM 14.08.1952*.

[14] TNA Acc.450/HE/178/16: Tanganyika Territory Director of Medical Services, *Letter to Archbishop Maranta, DSM 30.03.1953*.

[15] TNA 450/1283/13: J.R.C. Spicer, *Letter Assist. Dir of Med. Serv to E. Maranta. 30.10.1952*.

[16] TNA 461/27/1: Tanganyika Territory Provincial Medical Officer E.P. et al., *Annual Report Mahenge [11.12.1952]*; TNA 461/27/1: Tanganyika Territory District Commissioner Mahenge, *Annual Report Ulanga District 1952*. TNA 450/1283/13: J.R.C. Spicer, *Letter Assist. Dir of Med. Serv to E. Maranta. 30.10.1952*. In addition, Kwiro dispensary was seen as a "waste" because it doubled government facilities in Mahenge (who had just been refurbished, and staffed with a British Medical Officer). The services at Kipatimu were inadequate for a hospital grant, too. Mahenge Government Hospital in the 1950s never drew huge numbers of patients – on the contrary: time and again it was reported as an underused facility. TNA 450/1623: Tanganyika Territory Ministry of Health, *Annual Report of the Medical Department for year 1958*, p. 39.

[17] TNA Acc.450/HE/178/16: Tanganyika Territory Director of Medical Services, *Letter to Archbishop Maranta, DSM 30.03.1953*.

[18] TNA Acc.450/HE/178/16: Edgar Maranta, *Letter to Direct. of MS, DSM 22.04.1953*. TNA Acc.450/HE/178/16/134: Edgar Maranta, *Letter to Direct. of MS, DSM 28.04.1953*. Maranta kept the Dar es Salaam medical offices updated on his plans to bring a new doctor. TNA Acc.450/HE/178/16: Edgar Maranta, *List of Staff 1951*; TNA Acc.450/HE/178/16: Edgar Maranta, *Letter to Direct. of MS, DSM 22.04.1953*.

[19] Afrika Mission der Schweizer Kapuziner, *Jahresbericht der Schweizer Kapuziner in Ost-Afrika*, 1953.

[20] TNA 450/1283/13: *Letter Regional MO to DMSS. Morogoro 26.04.1952*.

## The Era of Dr. Carlo

Karl Schöpf, born in May 1919, studied medicine in Innsbruck during the years of the Second World War, with a somewhat shortened academic course. As a doctor on the front he witnessed the terrible carnage of the battles at Montecassino and also the impressive effects of penicillin in the Allied medical camps.[21] After the War, Schöpf went for eight months to Madison, Wisconsin for further surgical training, where he "saw progress in surgery with his own eyes", as he recounted in his CV and in interviews in 2008. When Schöpf returned to Zams, his family home, he quickly earned a degree as a specialist for surgery and practiced in the Catholic hospital for some time, but he was intent on leaving again, as he felt the rural Austrian home to be too "narrow".[22] In interviews, Schöpf told how he had already felt that Africa and the mission could be the career for him in his student days at the Catholic monastic school in Bregenz.[23]

Once the contact with Bishop Maranta had been established through Schöpf's brother-in-law who was a Capuchin, it did not take long for Schöpf and his young family to arrive in Ifakara in late 1953.[24] Schöpf now was a "mission doctor", albeit an "entirely unprepared" one. Only beautiful images of Tanganyika had been shown to Schöpf and his wife before they arrived in Ulanga. He brought neither training in tropical medicine nor a network of colleagues in tropical medicine. What he brought was a background in European and American surgery, which eventually fitted well the connections the mission had with Dr. Lehner's surgery division in Lucerne and with the Swiss Catholic Medical Mission Association more generally. Once in Ifakara, Schöpf realized that Müller's hospital in the 'stable' was not what was needed for a regular medical practice of surgery. He immediately set out to draw up plans for a hospital in Ifakara in which he could practice a kind of medicine "that came close to European medicine".[25] To a man like Schöpf who totally identified as a thoroughbred specialist surgeon, a good operating theatre was the most important element.

After Sr. Arnolda had taken Schöpf on tours into the homes of Africans for him to see with his own eyes the health situation and local arrangements of care and treatment in Ifakara, Schöpf's medical powers were quickly tested by local men, notably local healers. These were the

[21] Much of the following paragraphs is based on a series of interviews I did with Karl Schöpf and with Irmengard Schöpf in their home in Zams in 2007. Schöpfs biography and swift style of surgery earned him the qualification of a "war-hardened Surgeon" from the sisters (two different interviews done in Dar es Salaam, 2009).
[22] PAL Sch 1061.6: Karl Schöpf, *Curriculum Vitae*; Heinz Janisch, *[Radio broadcast] Menschenbilder: Irmengard und Karl Schöpf: Zuhause in Tirol und Afrika*, (2007).
[23] *Interviews with Karl and Irmengard Schöpf, Zams 23-25.07. 2007*.
[24] PAL Sch 1061.6: Edgar Maranta, *Letter to C.Schöpf. DSM, 28.08.1952*. Schöpf immediately signaled his interest in making use of his specialist knowledge in surgery, receiving a cautious answer by Maranta. The first contract in the files seems tob e from 1956, when Schöpf had definitely decided to stay with the Mission. PAL Sch 1061.6: *The Archdiocese of DSM with Dr. Karl Schöpf. Agreement for Service as Mission Medical Doctor. 14.03.1956*. PAL Sch 1061.6: Karl Schöpf, *Letter to E. Maranta. Zams, 06.09.1952*. PAL Sch 1061.6: Karl Schöpf, *Letter to E. Maranta. Zams, 23.10.1952*; PAL Sch 1061.6: Edgar Maranta, *Letter to C.Schöpf. DSM, 10.11.1952*.
[25] *Interviews with Karl and Irmengard Schöpf, Zams 23-25.07. 2007*.

first to come to him for operations, for hernias in particular.[26] After their successful treatment, Schöpf witnessed what he considered almost a frenzy for operations. Medication would no longer do, everyone wanted to be operated upon – and Schöpf immediately felt enthusiastic about his first couple of dozen of operations which he accomplished within the first weeks.[27] As the patients lined up at his post, it soon was the lack of beds and space which limited what Schöpf could achieve. P. Hieronymus supported the view that in the light of the masses of people now seeking medical care, the buildings which they had as a hospital could not be more than a temporary solution.[28]

The Government quickly recognized the potential value of a well trained doctor in Ifakara. However, as a result of Schöpf's war-related shortened theoretical training in medicine, the Tanganyikan administration refused to register him as a doctor and so he was given a medical license.[29] For the Mission, it seems from the tone of Maranta's writing at the time, this was a slight set-back. Yet Schöpf worked hard on his reputation as a surgeon and soon became a well respected medical man beyond the local arena. Maranta quickly grew into a steadfast supporter of Schöpf's, and left the doctor to do the medical work inside the hospital while he himself sought to manage the relations with government offices, and also engaged in health policy matters.[30] The Mission helped to reduce Schöpf's administrative duties and established an office for the administration, soon to be headed by Sr. Sara Kaufmann.[31] Sr. Arnolda was made matron of the hospital. Schöpf could therefore fully concentrate on his clinical, and especially his surgical, work without having to focus on hospital administration, staff recruitment and management, on the nuns' duties in nursing and domestic services, nor even on medical duties in the district.[32]

Therefore, the hospital grew into a complex institution, although not one that was very well connected to the rest of the medical services landscape. Fearing too much interference by government and too many abrupt changes in government policies, Schöpf and Schildknecht, after speaking with Sr. Arnolda declined a request by the local administration that Schöpf and the mission take over the duties of the Native Authorities dispensary in Ifakara, on terms similar

[26] *Interviews with Karl and Irmengard Schöpf, Zams 23-25.07. 2007*. Such treatments were also in great demand in Dar es Salaam's hospital for the Africans. TNA 450/HE1636: Tanganyika Territory Ministry of Health et al., *Report to HE the Governor [work of MoH during 1959]*.
[27] PAL Sch 1061.6: Karl Schöpf, *Letter to E. Maranta. Ifakara 25.06.1953*; PAL Sch 1061.6 Karl Schöpf, *Letter to P.Modeste. Ifakara, 8.7.1953*.
[28] PADSM Box 153 Ifakara Mission and Parish 4: Hieronymus Schildknecht, *Ifakara 1953*; *Nachrichten aus den Missionen*, in Providentia, 1952; TNA Acc.450/HE/178/16: Edgar Maranta, *Letter to Direct. of MS, DSM 03.12.1951*; PAL Sch 1060.5: Karl Schöpf, *Entwurf und Skizze des neuen Krankenhauses Ifakara. [25.06.1953]*.
[29] PAL Sch 1061.6: Tanganyika Medical Board, *Letter to E. Maranta. DSM, 13.07.1953*; PAL Sch 1061.2: Edgar Maranta, *Letter to Dr. Heinz Wolfram. DSM 28.06.1955*.
[30] PAL Sch 1061.6: Karl Schöpf, *Letter to E. Maranta. Ifakara, 06.12.1956*; PAL Sch 1061.6: Edgar Maranta, *Letter to C.Schöpf. DSM, 28.08.1952*. There were some minor conflicts with Dr. Schuster on dispensary medicine: PAL Sch 1061.6: Karl Schöpf, *Letter to E. Maranta. Ifakara 25.06.1953*.
[31] Sr. Sara, *Chronik des St. Francis Mission Hospital Ifakara*.
[32] *Interviews with Karl and Irmengard Schöpf, Zams 23-25.07. 2007*.

to those on which it had once taken over the hospital in Mahenge. Schöpf felt that the Mission could better push its medical enterprise entirely on its own:

> with a view to the future, when there will be a large [mission] hospital in Ifakara, it will be rather unpleasant to have government claim all kinds of dues and demands.[33]

Therefore, Schöpf also chose not to replace the Government Medical Officer Butler in Mahenge while he was on leave. Instead, he toured the entire Capuchin Mission, including Kipatimu, where he also trained the local dresser to perform circumcisions.[34] Clearly, the mission backed its own horse now.

## A New Hospital

While the Mission refused too close an association with government, it turned its promise into reality and spruced up medical services in Ifakara. The concrete plans for a new hospital seem to have developed rather rapidly after Schöpf's arrival. To Schöpf, it was unquestionable that a 'modern hospital' had to be built:

> "My plan was simple but adapted to all modern standards. Electricity and piped water were a sine qua non, as were modern hygienic installations, toilets, showers and baths. I am saying this, because at that time hospital planning was influenced by Albert Schweitzer's ideas at Lambarene, and his concept that local patients should be left in their traditional milieu; it meant thatched huts and earthen floors, where relatives could life as well. I was strictly against such a solution – I wanted a modern hospital!"[35]

Building in a medically modern fashion was difficult in the conditions of rural Africa, even at a comparatively well connected place like Ifakara. Ulanga at this time did not have many major building works. Thus knowledge of how to build a medical institution was hard to come by. Karl Schöpf himself officiated as the hospital architect and drew the basic plans.[36] A modern Catholic hospital in Ifakara was not going to look like the Catholic hospital in Zams, where Schöpf had been raised. Schöpf came up with a plan of a bungalow style hospital, but with an impressive main medical building. Such a plan allowed the extension of the hospital in well defined steps, and immediately put it in service once the medical core, the theatre and the laboratory, had been built in the main tract.

On August 7 1954, the first sod was turned on the hospital grounds. Building materials were expensive and hard to come by. The road system in the district was still so poor that building materials could not be transported during the rainy season.[37] Cement came from Dar es

[33] PAL Sch 1061.6: Karl Schöpf, *Letter to E. Maranta. Ifakara 11.02.1954*.
[34] PAL Sch 1061.6: Karl Schöpf, *Letter to E. Maranta. Ifakara 11.03.1954*; PAL Sch 1061.6: Karl Schöpf, *Letter to E. Maranta. Ifakara 09.07.1954*.
[35] Karl Schöpf, *Daktari Kalo erzählt*, 1997. As a doctor Schöpf thought in medical terms, but medical modernity was not confined to biochemical and surgical problems. Hospital architecture often expressed the social power of medicine as much as it tried to respond to bare technical necessity and organizational efficiency. Anne Digby et al., *At The Heart Of Healing*, 2008, chapter 1. Michelle Renshaw, *Accommodating the Chinese*, 2005. Schöpf was strictly against colours other than white and black on the walls of the leprosy care centre Nazareti: Interview Sr. M.P. 26.01.2010.
[36] In his home in Zams Schöpf showed me the blueprints he had drafted and kept with him.
[37] *Interviews with Karl and Irmengard Schöpf, Zams 23-25.07. 2007*. See also for an earlier account, but nicely depicting the problems: P. Aquilin Engelberger, *Bauen in Afrika*, in Seraphisches Weltapostolat des Hl. Franz v. Assisi, 1932.

Salaam (where it was in high demand in the 1950s).[38] At least the bricks were burnt locally, and the wood came from Ulanga. But that again meant that the mission had to find the money to buy the trees, the workers to cut them, and a way to transport the logs.[39]

Schacher, the man in charge of most of the building works was a stonemason, and two Swiss handymen, partly on transit from Congo, were engaged for the electrical wiring and plumbing work. The contribution of Capuchin brothers was crucial as they had expertise in constructing larger complexes, like churches and schools, in the Ulanga environment. But at least three of the Brothers in charge of building died between 1955 and 1957. Clearly a new generation of Brothers was needed. In March 1957, the Capuchins brought a young man to Ifakara, Br. Edwin von Moos, with whom "new life came to the building process".[40] Schacher found it difficult to bear the slow progress of the construction works. The number of workers was fluid and workers stopped their work "once they had earned enough money and could afford to feast". Sometimes – when the Mission ran out of money – workers were laid off by the employer, too. When timing was crucial for the construction works (e.g. in cement works) the mission engaged patients from the nearby leprosy camp, which was started in the early 1950s.[41]

The knowledge needed for the medical and equipment side of the hospital building process was rare or not always well brought together. Sr. Alphonsina had to be called in for two weeks to help with the X-ray facility, when the first installation had failed to function and it seems it had to be removed again.[42] There were no window shutters to protect the wards from the sun and heat. Toilets, closely attached to the wards, proved to be highly unsuitable in the tropical conditions.[43] In the TB hospital, built from 1961 without consultation with the sisters beforehand, storage facilities had been completely forgotten.[44] The provision of clean water was a problem from the beginning and remained so for a long time.[45] Nonetheless, these were minor things compared to the genuinely impressive look of the new hospital.

On 7 April 1957, the first set of hospital buildings were put into operation. In particular, this included the main building which to this day serves as the portal of the hospital. The architectural principle of the hospital is quite easy to understand. The clinic in the front building and each of the wards for African patients were set apart. Diagnostics and surgical treatment were located in the front building, nursing took place in the wards behind it. This section of the

[38] *Interviews with Karl and Irmengard Schöpf, Zams 23-25.07. 2007*. Berta Coninx-Girardet, *Britisch-Ostafrika*, 1951, graph p. 163.
[39] Paul Schacher, *Der Bau des Spitals*, in Missionsbote der Schweizer Kapuziner in Afrika, 1957.
[40] PADSM Box 153: *Chronica V [Capuchin Mission Ifakara]*, after for 28.12.1959. Br. Edwin remained in Ifakara into the new millenium.
[41] Paul Schacher, *Der Bau des Spitals*, in Missionsbote der Schweizer Kapuziner in Afrika, 1957. There was still a building team at Nazareti in the years 2000. Interview Sr. M.P. Baldegg 26.01.2010.
[42] *Mission*, in Providentia, 1957.
[43] PAL 1057.J.Briefe: Schwestern v. Baldegg; Einheimische Schwestern; Privater: Schwester M. Arnolda, *Letter to E. Maranta, Ifakara 12.05.1957*. *Interview with Sr. Ruth Gasche, Dar es Salaam, 08.02.2009*. Windows were later enlarged: *Interview with John Mapunda, Ifakara, 13.05.2010*.
[44] *Interview with Sr. Ruth Gasche, Dar es Salaam, 08.02.2009*.
[45] PAL Sch 1061.6: Karl Schöpf, *Letter to E. Maranta. Ifakara, 10.04.1957*. Interview with Br. Edwin von Moos.

hospital - with the exception of the building which contained the European' nurses accommodation - were bungalow-style detached wards containing 26-30 beds each.[46] These wards were connected to the main building via a covered passageway. The medical standards of equipment and interior finish the SFH were, according to a Baldegg sister who had then recently arrived, "almost like Sursee" – the Swiss small town hospital where she had trained and which was now run as a nurses training institute by the Baldegg congregation.[47]

***Services***

What the doctor needed for his work, especially the theatre, the lab and the X-ray section, was fully functional in 1957.[48] Other things at the hospital were still in the making. The maternity ward in the hospital buildings was temporary and for a while African mothers still gave birth to the children in the old maternity unit, before Sr. Arnolda moved into the new "B one" ward in October 1958 with a festive procession.[49] This delay in transferring the maternity unit, together with the distinctly white and prosperous look of the hospital, created fear in the African population of Ifakara that they were to be excluded from the new hospital, or at least would be asked to pay much more for the services.[50] Local women were reluctant to come for birthing to Sr. Arnolda: "So many fairy tales were told about the hospital, it was difficult to convince mothers to still come for giving birth."[51] Fears of exclusion soon changed into joy, at least according to the missionaries.[52] According to P. Hieronymus, 'everyone' was welcome in the new hospital, and so patients from all 'races' and faiths came to the hospital.[53] Compared to the period up to the early 1950s, this meant an obvious change. The 'Indian Ward' included a special room for maternity cases. In addition, the new hospital now attracted British, Greek, Indian and Arabian patients.[54]

Clearly, the new hospital in Ifakara resembled an urban social service institution for Africans. The new institution was multi-racial, operated with modern facilities throughout, offered a broad range of medical services, of which many were new and – not least – it had a large professional nursing staff. For Schöpf, it was a great joy to have moved into the new hospital, where "he could apply his capabilities to the best of what could be done in the circumstances" in Africa.[55] A bit of nostalgia for the old hospital remained among the older nurses after moving house: "With its narrow and dark rooms, and its primitive equipment it

[46] Sr. Sara, *Chronik des St. Francis Mission Hospital Ifakara*.
[47] Sr. Pankratia Stumpf et al., *Unsere Missionsschwestern*, in Providentia, 1957. This description might have been somewhat overstated though. *Interview with Sr. Ruth Gasche, Dar es Salaam, 08.02.2009*.
[48] The first installation had to be replaced.*Mission*, in Providentia, 1957.
[49] Sr. Pankratia Stumpf, *Bericht aus Ifakara*, in Providentia, 1959; Sr. Sara, *Chronik des St. Francis Mission Hospital Ifakara*.
[50] Maria-Paula Sr Wicki, *Schwester Maria Paula*, in Providentia, 1957.
[51] PAL 1057.J.Briefe: Schwestern v. Baldegg; Einheimische Schwestern; Privater: Schwester M. Arnolda, *Letter to E. Maranta, Ifakara 12.05.1957*.
[52] *Unsere Missionsschwestern*, in Providentia, 1957.
[53] PADSM 153/4: Hieronymus Schildknecht, *Jahresbericht Ifakara 1955*.
[54] Sr. Sara, *Chronik des St. Francis Mission Hospital Ifakara*.
[55] PAL Sch 1061.6: Karl Schöpf, *Letter to E. Maranta. Ifakara, 10.04.1957*.

remains in dear memory for the happy hours we experienced there in spite of all the poorness."[56] The old building remained in use for some time, for storage, but also as a place where the relatives of in-patients could sleep and cook meals.[57]

### *Cost*

Building this hospital was expensive for the mission and provoked some criticism for the luxurious standard of building and equipment. Even before Schöpf had arrived, Ifakara had already monopolized much of the resources for medical work in the mission.[58] Some voices in the mission noted that "the other hospitals, if they can be called so, should also be improved. But we lack the necessary financial means."[59] Therefore, when the new hospital was in the process of acquiring buildings and equipment, the mission procurator – who saw the financial flows in the mission and heard all the voices from Tanganyika – wrote from Switzerland, seeking reassurance from those in Ifakara:

> "This must be a very beautiful thing, once it is all done [...] at least according to the the orders coming in via the Bishop. Sterilization, X-Ray, beds. It is most probably not to be begrudged to the missionaries as well as the natives, that something better is provided. It was all too primitive up to now, or was it not?"[60]

At Ifakara, the mission propagandist wrote, one could confidently build a modern hospital and it would prove cheaper in the long term than to build something small "only to pull it down after some years and then build something more lavish [grosszügig]."[61] The use of the word "grosszügig" is quite interesting. Not only because it has an underlying message of generosity to Africans. It also shows a missionary practice of baroque extravagance, which was a well-established practice in the Church and made institutions stand out starkly against the background of an everyday lifestyle in rural Switzerland with its moral ideal of thrift.[62] Building lavishly was a symbolic statement indicating the important place of medicine and Development in the late colonial era mission. Put in a global perspective, however, the hospital was, if "measured in European terms, [...] very simple and without any luxury".[63]

Schöpf was aware that there were voices inside the mission organization who felt that the hospital was too large and luxurious, and sometimes he found these dissonances could prove

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[56] Sr. Franca Gulotti, *Im Dienste der Kranken*, in Missionsbote der Schweizer Kapuziner in Afrika, 1957. Nostalgia in mission nursing has been looked at by Elizabeth Hull, *Workplace Hierarchy and Moral Debate: Nostalgia for a Missionary Past Amongst Nurses in a South African Hospital* (paper presented at the AEGIS 2009, Leipzig, 2009).
[57] PAL 1057.J.Briefe: Schwestern v. Baldegg; Einheimische Schwestern; Privater: Schwester M. Arnolda, *Letter to E. Maranta, Ifakara 12.05.1957*.
[58] The modernization of Kipatimu was probably rather small, even the repair work in Ifakara was more costly, and Msimbazi hospital was no focus of investment from the mid 20th century. The only place where the Mission seems to have established a new bedded dispensary in the 1950s was Mtimbira. *Die Schweizer Kapuziner in Afrika. Jahresbericht 1953*, 1953, p. 7. In 1959 it ist he sisters who manage the 'hospital' in Kipatimu: Institutsarchiv Baldegg BIII,6,4: *Chronik Kipatimu*.
[59] S. Rufin, *Schweiz. Kapuzinermission in Afrika*, in Missionsärztliche Caritas, 1954.
[60] DAK folder "Pfarrei 1956-1969": P.Rufin, *Letter Schweiz. Kapuzinermission to Pater Hieronymus, Olten, 15.02.1954*.
[61] P. Hilmar Pfenniger, *Ulangaebene und Ifakara*, in Missionsbote der Schweizer Kapuziner in Afrika, 1957.
[62] What a change from Sr. Arnolda's pharmacy who had been presented as a model for efficiency at low cost and with basic means at the beginning: Gerard Fässler, *Vom Alpstein zum Muhulu*, 1932, pp. 115-116.
[63] P. Hilmar Pfenniger, *Unser Titelbild*, in Missionsbote der Schweizer Kapuziner in Afrika, 1957.

a problem.[64] It was not only the cost of the building that raised questions, but also the cost of drugs ordered for the hospital. Running a hospital demanded new economic and administrative procedures from the mission. Even before the opening of the new hospital, Schöpf had caused a small cash-flow crisis in the mission offices in Dar es Salaam with a large order of drugs. Schöpf promised to be more elastic by using cheaper medication. But he also argued that the mission dispensaries together ordered more drugs than he did for the hospital and that he, still in the old building, made a profit, not least because he copied the custom of government hospitals by charging for expensive drugs.[65] Such patient fees constituted a third field of disagreement about mission economy. "Some of the missionaries", Sr. Arnolda reported, "feel the doctor runs a fee structure which is unfair." Sr. Arnolda defended Schöpf and felt it was right that there was a considerable income generated through private patients.[66]

### *Science and Development*

The issue of secularization and medicine seems to have been projected onto the integration of a "field laboratory" for the Swiss Tropical Institute in a wing at the back of the hospital. Unlike conflicts in Mahenge about the secular activities and priorities that were part of mission medicine itself, the question now was one of cooperation with scientists who were clearly from outside the mission. Why should the mission and the Church contribute to research activities which were so clearly detached from any spiritual goal? Rudolf Geigy, the founder and director of the Swiss Tropical Institute had come to Ifakara a couple of times in the late 1940s and had established a field-base in Ifakara, from which he, and some of his fellows, undertook research in diverse fields of science, from ethnography to parasitology.[67] Now this field-base was turned into a permanent Swiss Tropical Institute Field Laboratory (STIFL), housed in the St. Francis Mission Hospital. The Mission's offer to accommodate a lab for the STI had come at the very beginning of the hospital building plans, and Dr. Schöpf was the initiator of these plans.[68] Those missionaries who were critical about the research lab complained that the STIFL received a building free of charge.[69]

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[64] PAL Sch 1061.6: Karl Schöpf, *Letter to E. Maranta. Ifakara, 08.08.1957*.
[65] PAL Sch 1061.6: Karl Schöpf, *Letter to E. Maranta. Ifakara 19.07.1955*.
[66] PAL 1057.J.Briefe: Schwestern v. Baldegg; Einheimische Schwestern; Privater: Schwester M. Arnolda, *Letter to E. Maranta, Ifakara 12.05.1957*. Some patients flew in from Zanzibar to Dar es Salaam to consult Schöpf: PAL Sch 1061.6: Karl Schöpf, *Letter to E. Maranta. Ifakara 25.01.1956*. Some patients also came from Aden: *Interviews with Edgar Widmer, Thalwil, 23.10.2008 und 27.10.2008*. On the issue of private patients see also further down in the section on race and nursing.
[67] Lukas Meier, *Tropenfieber*, 2007; Lukas Meier, *Swiss Science*, 2014. One of the first numbers of the STI's scientific journal *Acta Tropica* was devoted entirely to the missionary contribution to science (Vol II, nr 3, 1945). Capuchins and Baldegg Sisters had been in training in the STI from the beginning: Rudolf Geigy, *Training on the spot. Swiss development aid in Tanzania, 1960-1976*, in acta tropica, 1976, p. 295.
[68] Bishop Maranta and P. Hieronymus were considered amongst the greatest supporters of the STIFL, too. Thierry A. Freyvogel et al., *Forschung, 1997*, 1997; PADSM Box 156/ Ifakara STI Ifakara Centre 1: Rudolf Geigy, *Letter to E. Maranta. Basel 21.12.1954*; Lukas Meier, *Striving for Excellence*, 2012, p. 107.
[69] DAK folder "Pfarrei 1956-1969": Edgar Bishop Maranta, *Letters to Pater Hieronymus, Dar es Salaam, 16.01.1958, 26.01.1958, 27.01.1958*.

What Maranta and Geigy shared was their will to establish institutions that were relevant to the development of the people of Tanganyika. For Geigy's enterprise, the mission offered a great basic infrastructure and logistics and it helped Geigy to establish pioneering access to the hinterland. This arrival of a new Swiss institution in the mission field meant that, in a time of decolonization, the colony of the "Swiss" was strengthened, both in numbers and even in material assets like money, cars, or consumer goods. On the other hand, the research work of the Swiss Tropical Institute would really provide a contribution to the fight against tropical diseases. Maranta wrote:

> "If ever there is something useful resulting from the field lab, as in fighting Malaria, Relapsing Fever or Sleeping Sickness, we will profit too. It really seems to me that the mission can contribute a bit in the domain of research – not to speak of the positive response for the image of the mission here in Switzerland that we receive [.... ] If one says, that the STI has not produced anything in Ifakara up to now, then one might also say that we have not overly succeeded in fighting the general ignorance in the population."[70]

In the end, the Laboratory received an even larger space than in the original plans.[71] The manner in which Maranta now supported his doctor's pro-science initiative against criticism from within the mission is an indicator of the changes that had taken place in the decade since Maranta's rift with the Gabathulers in Mahenge.

### *The Governor's role*

Not every plan of Dr. Schöpf's could be realized though.[72] Nevertheless, Schöpf and the St. Francis Hospital quickly achieved fame and the original promise of the mission in the early 1950s that it was going to improve the conditions of the mission health services had led to the establishment of one of the largest and best equipped hospitals in the entire Territory. It would soon be serviced by three doctors, as the Government had hoped.[73] Indeed, at the end of 1959, all the hospital buildings, as proposed by Schöpf in the mid-1950s were completed and, by the end of 1960, the interior of all the wards were fully arranged. Two months before that, the hospital had been officially opened by the Governor of Tanganyika.[74] The timing of this 'official opening' had comparatively little to do with the medical functions of the hospital, since most of the hospital had been put in use step by step as soon as the wards, or new services were

[70] DAK folder "Pfarrei 1956-1969": Edgar Bishop Maranta, *Letters to Pater Hieronymus, Dar es Salaam, 16.01.1958, 26.01.1958, 27.01.1958*.
[71] PAL Sch 1061.6: Karl Schöpf, *Letter to E. Maranta. Ifakara 29.01.1956*.
[72] For example Schöpf failed to join the St. Francis Hospital into the network of the AMREF airborne medical services or even get his own plane as a flying ambulance: PAL Sch 1061.6 Karl Schöpf, *Letter to P.Modeste. Ifakara, 04.05.1954*. *Interviews with Karl and Irmengard Schöpf, Zams 23-25.07. 2007*. Michael Wood et al., *Different drums: a doctor's forty years in eastern Africa*, 1987.
[73] PADSM Box 153 Ifakara Mission and Parish 4: Hieronymus Schildknecht, *Ifakara 1953*; TNA 461/27/1: Tanganyika Territory District Commissioner Mahenge, *Annual Report Ulanga District 1957 [06.01.1958]*. Longford, an administrative officer in the district at the time remembered that SFH as "the best hospital in Tanganyika" Michael Longford, *Flags Changed at Midnight*, 2001, p. 301; TNA 450/1614/10A: Tanganyika Territory Provincial Medical Officer E.P., *Medical Department. Eastern Province. Annual Report 1958*. The province included, amongst other places, Morogoro with its government referral hospital
[74] PADSM Box 153: *Chronica V [Capuchin Mission Ifakara]*, entry for the 28.10.1960.

available. The official opening was tied to politics and administrative processes at the state level. The Governor had planned a tour in the Ulanga District, and the colonial administration suggested to Maranta, that he "may like to ask" the Governor to inaugurate the St. Francis Hospital "or to perform some other ceremony, e.g. to plant a tree to mark its completion."[75] So it happened. Turnbull visited the hospital, shook hands all around, and had tea with director, staff, and missionaries and unveiled a plaque commemorating the opening of the hospital by "His Excellency the Governor of Tanganyika Sir Richard Turnbull KCMG", although he was hardly the person who had contributed the most towards this hospital.[76] This tour of the Governor was marked by public discourse about Development.[77] Some chiefs, like Mahawanga in Ifakara, combined a discourse on 'piped water' and bad roads with the presentation of gifts of "tribal weapons" to the Governor.[78] In this context, the opening of the hospital entered the Church institution into a larger debate about modernization and nation building in the manner Bishop Maranta had most probably hoped for. Still, the official opening by the Governor at this late stage of colonialism leaves a strange symbolism for the hospital. The Territory was already gripped by a mass sentiment for independence or freedom ("*uhuru*") which could not but affect the mission. Governor Turnbull was replaced just about a year later by Prime Minister Julius Nyerere, the "hero of progress"[79]. The St. Francis Mission Hospital, built and put in service under the Colonial Mandate, was to continue in independent Tanganyika.

## Being a Patient at the St. Francis Hospital

In order to understand the history of patients, it is helpful to reconstruct the route an in-patient took through the hospital even though we cannot fully reconstruct this process.[80] How the patient was referred to the hospital or how s/he decided to come to the hospital remains a complex issue, and cannot be answered here.[81] From the moment of entry into the hospital, a complex process of a negotiation started with the patient navigating an environment of substantial control of the nurses and doctors over medicine and the patient.

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[75] TNA 461/V2/1: M.H. Dorey et al., *Letter to E. Maranta (copy to K.J. Schöpf). DSM 24.08.1960*.
[76] Edgar Widmer, *Geschichte der schweizerischen ärztlichen Mission in Afrika*, 1963, p. 49.
[77] TNA 461/V2/1: Tanganyika Territory District Commissioner Mahenge, *His Excellency's Tour of Ulanga. Mahenge 07.10.1960*; TNA 461/V2/1: J. Bradley et al., *Programme of His Excellency's Tour of Ulanga District 16.10.1960-29.10.1960. Morogoro 18.10.1960*; TNA 461/V2/1: *[People introduced to TT Governor during his visit to Ulanga]*.
[78] TNA 461/V2/1: Chief Ahamadi Mahawanga et al., *Welcoming speech of Chief Ahamadi Mahwanga, of Ifakara*. Similar in Mahenge: TNA 461/V2/1: John Mlolere, *[Statement at Governor's Baraza at Mahenge by Chairman of Ulanga Council]*.
[79] *Uhuru*, in Missionsbote der Schweizer Kapuziner in Afrika, 1960.
[80] I have learnt this approach from Howard Phillips in workshops held at Basel and Cape Town. See also his: Anne Digby et al., *At The Heart Of Healing*, 2008, chapter 6. On doing medical history see Flurin Condrau, *Patient's View Meets Clinical Gaze*, in Soc Hist Med, 2007.
[81] Research on medical pluralism, including my own interviews in Ifakara, show clearly that patients would go back and forth between different treatment offers (recent health system studies in Ifakara have laid much weight on the issue of 'access': "Access Programme". See also Paula Tibandebage et al., *Market Shaping*, in Social Science & Medicine, 2005; Helle Max Andersen, *Villagers*, in Social Science & Medicine, 2004. Sr. Ruth explained to me that with the exception of some particular diseases, most patients did not come to the hospital with a fixed idea in their head about the disease they should be diagnosed for: *Interview with Sr. Ruth Gasche, Dar es Salaam, 08.02.2009*.

Normally, the first port of call, and for most patients also the place where they were treated, was the outpatient section. Here, Sr. Arnolda[82] or Sr. Columba would receive the patient, open the patient card and collect the consultation fee.[83] Usually, these sisters would decide if a patient needed to be admitted to the hospital. Most cases would immediately receive medication.[84] The laboratory, run by Sr. Sara with a group of African staff helped in diagnosing, particularly the many cases of Malaria or Hookworm.[85] The process was still very much the same in the mid-1960s. At that time, a normal day at the outpatient-department saw 300 patients seeking services, a peak day up to 900.[86]

To be fully immersed into the system of 'hospital medicine', one needed to be admitted as an in-patient. Consultations with the doctor were rarely intimate; the entire family listened to the explanations from the doctor about the sickness and its cause.[87] A hospital like St. Francis, with its limited number of biomedically trained staff and with its many open doors offered a rich array of alternative ways to avail of and to comprehend medicine.[88] The hospital engulfed its patients in an experience of 'modernity'. After the cautious start, the patients soon flocked to the hospital, impressed with the electric light, whitewashed wards and organized wards.[89]

The image of patients given by hospital staff was divided. On the one hand, there was the perception of a "great eagerness to undergo surgery" or to receive injections. On the other, the hospital staff experienced non-compliance from the patients towards the disciplinary aspects of the hospital. These aspects involved, in particular, European concepts of "cleanliness". In the eyes of the nurses, the new hospital wards looked less "bright and clean" soon after they were put into use. Patients kept "all kinds of objects in their beds: knives, stones, money, herbal medicine, sugar too, and, it was said, "some of the most unspeakable objects and dirtiest rags […] under blanket and pillow."[90] Schöpf repeatedly stated to me that he was tolerant towards popular practices of medicine.[91] Nurses would also discuss with patients and relatives about the correct treatment and how care should continue once the patient left the hospital. Patients' expectations of care were rather modest in the eyes of the nurse. The core task of nursing was

[82] PADSM Box 153 Ifakara Mission and Parish 4: Hieronymus Schildknecht, *Ifakara 1953*.
[83] There was an interesting nickname for the sister working at the 'reception', Sr. Kasumuni. The name seems to come from her question addressed to the patient to pay 50 shillings for the patient card and services. *Interviews with Susana Ngomaholo, Ifakara, 12.04.2009, revisit 07.05.2010*.
[84] *Interview with Sr. Ruth Gasche, Dar es Salaam, 08.02.2009*. in the 1970s it was still often the nurses who admitted patients: *Interview with Matron Stella Ngidula, Ifakara, 08.04.2009*.
[85] Rolf Diethelm, *Erinnerungen an Ifakara. Aus den eigenen Notizen (Tagebuch) über meine Tätigkeit in Afrika 1959/1960*, (Altdorf2006), p.5.
[86] Sr. Bernardina Allenspach, *Sr. Bernardina Allenspach schreibt aus dem San Francis Hospital Ifakara, Tanzania*, in Missionsärztliche Caritas, 1967.
[87] *Interviews with Edgar Widmer, Thalwil, 23.10.2008 und 27.10.2008*.
[88] I was told stories of alterantive medicines being brought into the hospital, for example in an interview I did with a female healer in Ifakara in 2010, who herself supplied these kind of medicines.
[89] Maria-Paula Sr Wicki, *Schwester Maria Paula*, in Providentia, 1957.
[90] Sr. Franca Gulotti, *Im Dienste der Kranken*, in Missionsbote der Schweizer Kapuziner in Afrika, 1957.
[91] *Interviews with Karl and Irmengard Schöpf, Zams 23-25.07. 2007*. *Interview with Sr. Ruth Gasche, Dar es Salaam, 08.02.2009*. Dr. Widmer exchanged gifts and knowledge with a local healer called Mojo living in the Igota area *Interviews with Edgar Widmer, Thalwil, 23.10.2008 und 27.10.2008*.

the management of the treatment course, i.e. the correct and timely dispensing of medication, injections. Hygiene was managed in a pragmatic manner. Beds and bedding had to be clean, but the linen was not 'white' as it would have been impossible to keep it spotless.[92] Rearranging the bedding, giving medicine and dressing wounds would make a patient happy throughout the day. Many of the care tasks were done by the kin, who would often be at the bedside and satisfy the small wishes of the patient.[93] Relatives were an integral part of the nursing at St. Francis hospital. With only a small number of nurses working in the ward, relatives were meant to give much of the daily care, and they were crucial as providers of food. The infrastructure of the hospital reflected this set-up. On the other hand, the hospital offered some infrastructure for those who accompanied the patients. At the start, some patients who needed little medical attention were even lodged directly in this camp. In 1961, this camp was moved and re-built with the aid of the Prof. Geigy.[94]

According to Schöpf's recollections, there was no proselytizing in the hospital. He had applied, he claimed in an interview, the policy he had known from Zams: "it is a hospital led by Catholic people, that's it."[95] Yet this still suggested that the hospital was spiritually a Catholic space. From late 1959, there was a chapel in the hospital premises and a chaplain caring for the spiritual needs of the patients. In a mixture between Christianization and a Catholic pastoral monopoly, the hospital priest cared for Catholics, as well as for any other religious group of patients. The presence of the chapel was an important feature, because it turned the hospital into an autonomous religious institution. The nurse-nuns could live in their own convent situation on the hospital grounds, marking the hospital as a full blown hospital steeped in the tradition of religious care institutions. A more regular and popular opening perhaps followed a little later, when Sr. Arnolda initiated the rosary prayers twice a day in the chapel. It was also Sr. Arnolda who ordered crucifixes for Ifakara, as there were many rooms in the new hospital without crosses on the wall.[96]

Nuns hoped that this was producing a spiritually persuasive effect coupled with physical recovery:

> "During the long hours on the sickbed the eye meets the cross on the wall. The hand takes the Catholic journal [...] the patient witnesses the priest offering the Eucharist to a Catholic

[92] *Interview with Sr. Ruth Gasche, Dar es Salaam, 08.02.2009*.
[93] Sr. Franca Gulotti, *Im Dienste der Kranken*, in Missionsbote der Schweizer Kapuziner in Afrika, 1957. The mission had sometimes experienced that kin support was not always available: In her medical practice Dr. Schuster complained that many of those who were very sick, seemed to have no kin, which left the difficult care arrangements too often in the hands of the mission staff Adelheid Schuster, *Die Missionsärztin erzählt*, in Missionsbote der Schweizer Kapuziner in Afrika, 1952.
[94] Sr. Sara, *Chronik des St. Francis Mission Hospital Ifakara*. The situation for care givers, especially when their relatives needed substantial care over a long period, was difficult. Often they slept on the benches just outside the wards, plagued by mosquitoes. Interview Sr. M.P. Baldegg 26.01.2010.
[95] *Interviews with Karl and Irmengard Schöpf, Zams 23-25.07. 2007*.
[96] PADSM Box 153: *Chronica V [Capuchin Mission Ifakara]*. Sr. Sara, *Chronik des St. Francis Mission Hospital Ifakara*. PAL 1057.J.Briefe: Schwestern v. Baldegg; Einheimische Schwestern; Privater: Schwester M. Arnolda, *Letter to E. Maranta, Ifakara 12.05.1957*.

> patient. [ ...] many of our sister's medicines are not killing bacillus only [...] but prejudices, too."[97]

All these events point to a practice of healing charged with spiritual medicines, particularly in the eyes of patients, who witnessed all these materials and rituals which firmly anchored Catholic objects in the ontology of healing of hospital medicine at SFH. "Catholic medicines" clearly were part of the *dawa* available at the hospital.[98]

Ever more patients received services in the hospital. From the beginning in April 1957, the number of in-patients rose steadily, from about 700 to roughly 4,000 per year 10 years later. The wards were "always full", sisters Columba and Pankratia reported.[99] Almost every day, after Schöpfs arrival in 1953, patients were operated on.[100] In 1957 more than 50 operations of which 19 were "major" ones - were done in a single month of that year alone and the number of in-patients totaled 857 by the end of the year.[101] Dr. Diethelm who came to replace Schöpf for about 9 months in 1959 was the last to be in Ifakara as a solitary doctor. In 1960 in-patient numbers almost doubled within just one year to almost 2,200 and out-patient consultations for the first time rose above 100,000 in just one year.[102] With the numbers of doctors rising to four by the end of the 1960s, the number of large operations performed in the main operation theatre in Ifakara rose up to almost 2,000 in 1966 and 1967 and then to almost 3,000 in 1968. Surgery was general, but that meant it was a mix of 'specializations' in which Schöpf and his team excelled and other things that could not be done, because the skills were lacking.[103] A specific field of 'specialization' was male circumcision, which was in the hands of Africans who had been trained by Schöpf to perform the operation and used the theatre of St. Francis Hospital for the procedure. Adam Lihimba was reported to have done a couple of hundred circumcisions without any complications.[104] Although these patients were hardly counted in the numbers cited above, the majority of the in-patients in the hospital were males in any case. This finding is important, not only because it hints to a gendered approach to (hospital) health care in Ulanga, but also because it risked the creation of a gender inequality on the economic side of medical welfare.[105]

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[97] P. Meinhard Inauen, *Ifakara - das Tor zur Welt*, in Missionsbote der Schweizer Kapuziner in Afrika, 1957, p 134. See for an argument ab Catholics being led back on a righteous way of life: Sr. Franca Gulotti, *Im Dienste der Kranken*, in Missionsbote der Schweizer Kapuziner in Afrika, 1957. See for examples of baptism on the hospital bed:*Aus Missionsbriefen*, in Providentia, 1953.

[98] Interviewees related a situation of patients with diverse religious background and where patients were not force-fed Catholicism e.g. *Interview with John Mapunda, Ifakara, 13.05.2010*.

[99] *Unsere Missionsschwestern*, in Providentia, 1957. Sr. Franca Gulotti, *Im Dienste der Kranken*, in Missionsbote der Schweizer Kapuziner in Afrika, 1957.

[100] PADSM Box 153 Ifakara Mission and Parish 4: Hieronymus Schildknecht, *Ifakara 1953*. PADSM 153/4: Hieronymus Schildknecht, *Jahresbericht Ifakara 1955*.

[101] *Unsere Missionsschwestern*, in Providentia, 1957.

[102] Sr. Sara, *Chronik des St. Francis Mission Hospital Ifakara*. Anonym, *Auch Zahlen können sprechen*, in Jahresbericht, 1960.

[103] *Interviews with Karl and Irmengard Schöpf, Zams 23-25.07. 2007*.

[104] Rolf Diethelm, *Erinnerungen an Ifakara. Aus den eigenen Notizen (Tagebuch) über meine Tätigkeit in Afrika 1959/1960*, (Altdorf2006), p.7. Interview Lihimba.

[105] TNA 450/1563/3: *Annual Report Eastern Medical Region, 1954 [statistics]*. In 1958, 614 male and 419 female in-patients were reported. Although we do not have the numbers for these early years, we can see that in the late 1980s the cost per

The in-patient numbers at St. Francis Hospital were always high and the impression one gets is that the hospital was not trying to send people on the cheapest medical course, i.e. keep them out of the hospital walls. But neither the cash books, nor the patient cards of that time are in the archives. So we do not know what financial considerations were made when patients came. Certainly, the non-Mission private patients were a source of income.[106] African patients also had to pay fees and this is still vividly recollected in oral memory.[107]

## Working at St. Francis Hospital

The establishment of the St. Francis hospital introduced a substantial change in the presence of professional groups in Ulanga and most notably in Ifakara. The hospital brought a larger number of European trained staff, a number big enough for medical specialization. The hospital also added fully qualified African professionals to its nursing staff. Additionally, the hospital offered a large number of new training opportunities and positions on different levels to the African community in Ifakara. African staff numbers grew constantly from the early 1950s. In 1952, there were at least three male African dressers working with the Mission in Ifakara, and Sr. Arnolda also had her co-workers at the maternity unit.[108] In 1953, eight dressers were enumerated as working in Ifakara and, in 1955, sixteen African staff worked at the hospital.[109] By 1961, the African staff had considerably increased. The Hospital chronicle counted two certified dressers, four certified nurses, and 13 uncertified dresser, as well as eight female assistants, including those who worked at the maternity wards, and 23 other staff were also listed. At the end of 1963, they worked alongside four or five doctors, nine Baldegg nurses, and seven non-convent nurses from Switzerland and Austria.[110]

The first group of medical workers under Sr. Arnolda in her days as the keeper of the dispensary and then as a matron of SFH and under Dr. Schöpf were recruited from the local

patient day for males seemed to be considerably higher than those for female patients. In the 1990s full cost were compared in a study at SFH and it showed that male patients at the medical ward cost 40% per day than female patients in obstetrics. ASML R3T6O1quer Vor 94 Diverse Berichte Tanania SFDDH: Lucy Gilson et al., *Recurrent cost analysis of selected patient care centres in SFDDH, Ifakara, 17.06.1991*, p. 29.

[106] The fee structure is not clear from the Hospital Chronicle, notably because it remains unclear if fees were daily or per admission/operation. It seems that a day in the General Medical Wards was shs 10/- (children:shs 5/-); and from oct 1960: shs 15/-. Operations cost shs 30/- (from 1959: shs 40/- ; from 1960 Shs 50/-) From March 1960 there were two classes in the private ward, first class cost 50 Shs/ per day from 1960 Sr. Sara, *Chronik des St. Francis Mission Hospital Ifakara*.

[107] Focus Group Discussions in Ifakara, May 2010. Interview with Susanna Ngomaholo, 2010. The missionaries considered it as a small fee: Im Rahmen des Projektes www.humem.ch. Humem et al., *Interview mit Sr. Maria-Paula Wicki. Baldegg 09.09.2009*.

[108] Pirmin Mzenga, Augustine Hermes, Thomas Hermes are named in: DAK folder "Correspondence: Ifakara Mission 1941-1944": *Ifakara African Census, 1952: orodha ya wahesabuji (Enumerator's)*. Theresia Palaham must have been at the maternity.

[109] PADSM Box 153 Ifakara Mission and Parish 4: Hieronymus Schildknecht, *Ifakara 1953*. PADSM 153/4: Hieronymus Schildknecht, *Jahresbericht Ifakara 1955*. Only the European staff is counted in: S. Rufin, *Schweiz. Kapuzinermission in Afrika*, in Missionsärztliche Caritas, 1954.

[110] Sr. Sara, *Chronik des St. Francis Mission Hospital Ifakara*, entry that gives staff at on 31.07.1961. These numbers were about the same in 1962: DAK folder 'Pfarrei 1956-1963': *Spital 1962 [staff and salary list, African staff]*; ASTIBS 6/2/6 "S.Francis Hospital": SFH, *Jahres-Bericht 1962 des St. Francis Hospitales Ifakara*.

Catholic community. Sr. Arnolda had trained and hired assistants in maternity for a long time (see chapter 3). With the hospital growing she also recruited young boys as assistants for the doctor, for example Adam Lihimba.[111] People like Lihimba were often very loyal towards the hospital. Those whom I was able to interview were proud to have worked at the St. Francis Hospital.[112] After many years of on-the-job training, they had great medical capabilities, often a considerable grade of specialization, but the careers of this first generation of local health workers were hampered by the absence of formal qualifications and they were thus bound to the hospital. Certainly, when the St. Francis Hospital was started and these young people started their careers as health workers, the Mission was still seen as a major, and almost sole, provider of qualified training in Ulanga and it would have been difficult, if not impossible, to foresee the importance of formal qualifications for a local African. The mission hospital experience in professionalization showed that locally trained African staff must not necessarily have been less capable in nursing than formally trained staff, especially when it came to the empathic qualities in nursing care.[113] Later however, this generation lacked the papers, *cheti* in Kiswahili, which made them eligible for most of the standard positions – especially after the designation of the hospital as a district hospital in 1976, when the government started to 'second' staff to the hospital, and formal professional categories became more pronounced. Particularly from this point in time – the redesignation of the hospital – the African staff at the hospital was categorized by contractual provenance and *cheti* status.[114]

## Nurses

The workload at the St. Francis Hospital also meant that the Mission could not do without professionally trained African nursing staff. While the hospital was being built, the Tanganyika medical administration started to establish training schemes for African nursing. Missions played a huge role in nurses' training, as the political administration identified training as one of the major fields where missions could contribute to the health services.[115] The inclusion of

[111] Interviews with Adam Lihimba, and other staff. *Interviews with Karl and Irmengard Schöpf, Zams 23-25.07. 2007.*
[112] Note that the my sample was almost exclusively staff who had worked for a long time at the hospital.
[113] Majella Lenzen, *Das möge Gott verhüten*, 2009, p. 89 argues for better performance of assistant staff when it came to monitoring patients carefully.
[114] *Interview with Matron Stella Ngidula, Ifakara, 08.04.2009*. Staff with contracts from the Church, i.e. the Diocese of Mahenge, mostly did not receive the same salary as the staff in nationally regulated government positions were supposed to earn. On the other hand, government positions were only accessible on the basis of qualifications on paper, while the Church could train or employ staff based on personal loyalty or recommendation. In the later years African staff was very keen to go for training and earn the *'cheti'* which spurred or sustained their professional careers. However, these perceptions of other sub-professional groups would have to be studied carefully, as there is, in general, great intra-professional dissonance of interests. Peter M. Haas, *Introduction: Epistemic Communities and International Policy Coordination*, in International Organization, 1992.
[115] TNA 13350 Vol III: R.E. Barrett, *Review of Medical Training, April 1951*. TNA 10409 vol II.: Barclay Leechman, *The Medical Training grants for Health Workers Regulations, 1951 [DSM 11.07.1951]*. TNA 10409 vol II.: Conference of Provincial Commissioners Tanganyika Territory, *Extract from the record of Conference held at Dodoma in January 1951*. There were also training programs for other types of African staff, notably Sanitary Inspectors and African Nursing

mission in the training probably accelerated the government policy of feminizing nursing.[116] It is quite obvious that the recruitment for the nursing profession was aimed at girls from respectable, not least Christian, families:

> "Nursing is one of the most satisfying careers for girls. The training which is given, in the prevention of sickness, by the promotion of personal and domestic hygiene, the welfare of children, and the care of the sick, is of great value throughout a woman's whole life. Whether she devotes her time entirely to the care of her family or continues in general nursing work, she should be a powerful influence among her neighbors with her knowledge of healthy living and the care of children and so can do a very great deal to lessen the burden of ill-health on the community in which she lives. [...] in no case is any girl posted to a hospital unless the most careful arrangements have been made for her accommodation and supervision. [...] Marriage is now no longer a bar to continuation in the Junior service..."[117]

Missions now started to train nurses in a number of places. Out of twelve training centres in 1955, eight were run by missions and four by the government.[118]

The Ifakara Mission was one of the places where missionaries were prepared to train Africans.[119] The archives, as far as I have seen them, are very quiet about nurses' training in the St. Francis Hospital, though. In interviews with myself in 2007, Dr. Schöpf explained that the training of "nurses" had been important for the hospital. Training took an important position in the daily work routine, but it was a very informal form of training and entirely based on bedside teaching.[120] Probably, the nursing staff in question was trained for one year, and we must assume it was training for work at a hospital, but it would still have fitted these 'nurses' well into the government plans for "Village Nurses" if that had actually been implemented. Training for the Village Nurse grade did not require a specific educational standard and concentrated on practical work. Examination was meant to be done locally and there were no certificates of qualification issued. This was a very basic regulation and meant that training was a function of local needs and possibilities. This scheme for Village Nurses was very much fitted to serve the situation in the missions.[121]

It is difficult to understand why the Capuchin Mission did not successfully engage in the structured training schemes of nurses.[122] Considering their background in Switzerland – where the Baldegg community ran medical training institutions as an essential part of girls' training – and their vested interest in girls' education in Tanganyika, we wonder at the lack of formal

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Assistants. TNA 24856: *[fotos]*; TNA 24856 folio 24A: *Memorandum Regarding Proposals for the Creation of the Sanitary Inspectors Training Section of the School of Hygiene Medical Department, DSM*; TNA 10409 vol II.: G.K. Whitlamsmith, *Memorandum for the Provincial Commissioners' Conference: Training of African Village Midwives [DSM 05.12.1950]*; TNA 10409 vol II.: Barclay Leechman, *Memorandum No 38 for Executive Council: the Training of rural health Workers [DSM 07.03.1951]*.

[116] Helen Sweet, *Mission To Nurse*, 2013. *Enter fn global concepts of nursing, zb diakonessen,zb laternenlady, etc. fette nursing footnote here. Auch pascal etc*TNA 13350 Vol III: Barclay Leechman, *Member's Circular Letter No. 3 of 1951 to: All Provincial Commissioners [13.06.1951]*.

[117] TNA 13350 Vol III: B.I. Schofield, *Medical Dept. Circular No. 41/1951 re Nursing Training for Girls*.

[118] Jan P. van Bergen, *Development and Religion*, 1981.

[119] TNA 61/ 351 Vol II: Tanganyika Territory District Commissioner Mahenge-Ulanga et al., *Letter to Assist. Dir of Med Serv, Morogoro. 30.06.1952*.

[120] *Interview with Sr. Ruth Gasche, Dar es Salaam, 08.02.2009*.

[121] TNA 10409 vol II: N.N., *File Title!*, note 99, dated 09.02.1952.

[122] The major training institutions attached to the SFH was the RAC (as we shall see in the next chapter).

training. Indeed there had been an idea – as a part of a three-year plan – in 1963 to establish a training centre for nurses and midwives, but it was the third step in sequence that prioritized a separate obstetrics department, a separate out-patient-department and, only then, the training centre. Given the financial prospects, this school never seems to have even made onto the drawing board.[123] Was the eventual failure to establish the school also an expression of the unstable professional position of the Swiss nurses (keeping in mind the problems of registration) joined with a reluctance to open their community to non-Swiss which made the sisters leave this field largely untouched? Whatever the exact reasons, the absence of a nurses' training school at such a large hospital is not a minor issue, as it laid important institutional foundations for the development of St. Francis hospital. It meant that the hospital concentrated on and emphasized medical services of a transnational standard, or rather of a Swiss-Ifakara specificity – at least for as long as comparably cheap replenishment of the nursing force from Europe was available either through mission channels or thanks to subsidies of development cooperation agencies. On the other hand, St. Francis Hospital would have to continuously attract nurses from other places in Tanzania, even as the local knowledge gained by experience must have been considerably strengthened by the lack of other opportunities afforded to the nursing staff by the national professional regulations.

While nursing in Ifakara was thoroughly feminine when it came to European nurses, African nursing in Ifakara retained a male element for some time to come, with male nurses working under white female nurses. A nurse from Switzerland explained that:

> "Female staff is not so suitable for nursing work, mainly because the girls are marrying at a very young age [...] thus we have to make do with male staff and that works out quite well."[124]

Nonetheless, a trend for a feminization of care, and to make the nursing profession female, can be discerned in the later history of SFH, too: when the position of the matron was 'africanized' from the late 1970s it was female nurses who took over this position from the Swiss.

With the opening of the first wards of the new hospital, there seems to have been a conflict with some of the African nursing staff. Some seem to have been fired, and new staff ideally had certificates, so that they were entitled to receive government grants.[125] Eventually,

[123] ASTIBS 6/2/6 "S.Francis Hospital": Karl Schöpf, *Ansuchen um finanzielle Hilfe zum weitern Ausbau des Ifakara Krankenhauses sent to Miserior, Aachen. Ifakara 10.07.1963*. In 1967 step two, the OPD, had probably turned into the priority action, but there were still not the funds available: ASTIBS 6/2/6 "S.Francis Hospital": SFH et al., *Annual Report 1967 for St. Francis Hospital Ifakara*. In the era of Schöpf successor Oskar Appert the idea of training was transferred from nursing to doctors, i.e. Medical Assistants at the St. Francis Hospital. See: PADSM Box 155 Ifakara SFH 2: St.Francis Hospital Ifakara et al., *SFH Ifakara: Jahresbericht 1969*, p. 9. PADSM Box 155 SFH 6: St.Francis Hospital Ifakara et al., *Jahresbericht 1971*, p. 2. See also chapter 9.

[124] Sr. Franca Gulotti, *Im Dienste der Kranken*, in Missionsbote der Schweizer Kapuziner in Afrika, 1957.

[125] PAL Sch 1061.6: Karl Schöpf, *Letter to E. Maranta. Ifakara 29.01.1956*. Later Tanzanian nurses were classified according to training into A- and B- nurses, see eg: ASTIBS 6/2/6 "S.Francis Hospital": SFH et al., *Annual Report 1967 for St. Francis Hospital Ifakara*.

the crisis was overcome with new arrivals from Europe.[126] When the hospital brought trained nurses in 1958, Schöpf had to formalize the contractual situation. He copied the contracts which the Catholic Hospital in Ndanda signed with its nurses. These contracts stipulated formal modern labour relations, including paid leave, continued salaries in the case of sickness, lodging in a brick house, and the attempt to enforce exclusive work for the hospital. He had these contracts signed by the male nurses, Hilmar and Thomas, and the two female nurses, Susana and Monika.[127] At that time, a full wage for a male nurse was typically just above Shillings 220.[128] Nurses were unhappy with wages and demanded pay rises:

> "our registered nurses are absolutely unhappy [about their salaries] and continue to importune [...] and since our African nurses are well connected to other hospitals and know exactly that these new wages are being paid, they are no longer willing to be acquiesced."[129]

Indeed, African health care staff touched only a fragment of the total salaries paid.[130] In 1962, there were more women nurses with full training on the staff list (five out of a total of seven), but the highest wage was paid to a (Protestant) male nurse. The lowest wages were paid in the maternity unit where only women worked.[131] Theresia Palaham, a long-time collaborator of Sr. Arnolda, received food, unlike most other staff, but in cash she earned just over 10 per cent of what the best paid African nurse reached.[132]

Tanganyikan nurses and nurse assistants were assigned wards. The trained nurses shared the task of managing a ward with the European nurses. Often they were important translators, especially when people spoke local languages rather than Kiswahili.[133]

John Mapunda came from the lakes region and had trained in the Benedictine Mission hospital in Peramiho, and had also worked for nine months at a peripheral Mission dispensary before he came to work in Ifakara in 1963. He had been drawn to Ifakara because friends from his student days were now working at the St. Francis Hospital and had told him that it was good work and that the salary was slightly better than at Peramiho. There was not enough nursing staff, Mapunda remembers, and he was surprised to see Muslim staff working alongside

[126] PAL Sch 1061.6: Karl Schöpf, *Letter to E. Maranta. Ifakara 29.01.1956*; PAL Sch 1061.6: Karl Schöpf, *Letter to E. Maranta. Ifakara, 20.03.1958*.
[127] DAK folder 'Pfarrei 1956-1963': Diocese of Ndanda, *Vertrag zwischen Krankenpfleger und Ndanda Diocese. 01.01, 1958*; PAL Sch 1061.6: Karl Schöpf, *Letter to E. Maranta. Ifakara, 27.03.1958*.
[128] Similar wages at Ndanda: PAL Sch 1061.6: Sr. Wilma *Letter to Dr.Schöpf. 13.03.1958*.
[129] PAL Sch 1061.6: Karl Schöpf, *Letter to E. Maranta. Ifakara 13.02.1962*. *Interviews with Susana Ngomaholo, Ifakara, 12.04.2009, revisit 07.05.2010*. *Interview with John Mapunda, Ifakara, 13.05.2010*.
[130] TNA Acc.450/HE/178/16: Edgar Maranta, *Letter to Direct. of MS, DSM 14.08.1952*. PADSM Box 155 Ifakara SFH 2: St.Francis Hospital Ifakara et al., *Statement of Account, SFH 01.01.1968-30.06.1968; Budget 1968*.
[131] "Full training" remains unclear, Sr. Ruth remembers that in the early 1960s African nurses were trained on the job and recruited directly from mission schools. *Interview with Sr. Ruth Gasche, Dar es Salaam, 08.02.2009*.
[132] This might also reflected a 'traditional' practice of midwifery, which demanded that *posho*, i.e. food, was brought to the midwife as part of the social and ritual transactions included in childbirth. Marja-Liisa Swantz, *Women/Body/Knowledge*, 1994.
[133] *Interviews with Susana Ngomaholo, Ifakara, 12.04.2009, revisit 07.05.2010*. Ngomaholo was one of the first, if not the first trained female nurse at St. Francis Hospital, starting in 1958. Originally from Ifakara she went to the girls school in Mahenge, where she decided to go into nursing rather than teaching and trained in the Mwanza area. She never found the time to upgrade her training from B to A nurse as she headed a household and needed regular income.

Catholics.[134] Working as a nurse in the TB section from about 1970 in the surgical ward, Mapunda vividly remembered the night shifts as a great challenge. African nurses were assigned for the night shift during an entire month. With only two nurses on duty for well over 200 patients, it was hard work, especially in the children's ward where nursing and young children often cried for long periods in the night. Day shifts were more interesting in his eyes, as it meant that Mapunda worked alongside nurses from Europe and he appreciated what he could learn from their practice.[135]

The number of white medical staff in Ifakara rose dramatically in the 1950s. At the beginning of the decade Sr. Arnolda had been the only white medical professional in Ifakara. In 1953, there were already two nun-nurses and three 'lay' nurses working at St. Francis. In 1955, three nuns permanently worked at the hospital alongside two lay nurses.[136] From the early 1960s and throughout that decade – the peak of white nursing work in the hospital – nine Baldegg sisters and seven 'lay' nurses worked alongside three doctors.[137] Most of these nurses were not only new to Ifakara, they were also new arrivals in Tanganyika.

From the beginning, Schöpf knew that he needed additional staff to run a hospital. In 1953, when Schöpf still hoped that the hospital could be operative 18 months later, he asked for "specially trained nurses, nuns much preferred" for work in the laboratory, X-ray department, and in the operation theater.[138] Later Schöpf asked Maranta to support his requests about nuns from Baldegg for Ifakara and especially about their training.[139] The doctor was not shy to ask for specific, experienced nurses whom he already knew from other Mission stations and he remained nervous about the quality of medical training Baldegg could provide. For Laboratory work for example, he asked to have a sister who was trained especially and in a "large lab". Willingness to accomplish the assigned work, which the lay nurse in charge clearly showed, could not replace the knowledge "of complete laboratory work" needed in St. Francis Hospital.[140] Neither did Schöpf like the combination of specializations, like X-ray and laboratory. He preferred a clear-cut identity in one specialized field.[141]

The sisters who trained in the Baldegg-related institutions in Switzerland were trained for mission work, too. Even to a specialized field, like laboratory work, a substantial midwifery course was added, "after all, it was for the Mission that one was trained."[142] In Baldegg, the

[134] There was, however, an amount of preference for Christian ethics in the nursing staff: *Interview with Sr. Ruth Gasche, Dar es Salaam, 08.02.2009*.
[135] *Interview with John Mapunda, Ifakara, 13.05.2010*.
[136] PADSM Box 153 Ifakara Mission and Parish 4: Hieronymus Schildknecht, *Ifakara 1953*; PADSM 153/4: Hieronymus Schildknecht, *Jahresbericht Ifakara 1955*.
[137] ASTIBS 6/2/6 "S.Francis Hospital": SFH, *Jahres-Bericht 1962 des St. Francis Hospitales Ifakara*.
[138] PAL Sch 1061.6 Karl Schöpf, *Letter to P.Modeste. Ifakara, 06.08.1953*.
[139] PAL Sch 1061.6: Karl Schöpf, *Letter to E. Maranta. Ifakara, 08.08.1957*.
[140] PAL Sch 1061.6: Karl Schöpf, *Letter to E. Maranta. Ifakara 05.08.1953*. PAL Sch 1061.6 Karl Schöpf, *Letter to P.Modeste. Ifakara, 04.05.1954*. The nurse in question was soon replaced by Sr. Maria Paula, and continued her career in Ifakara as the great figure of the hospital's administration for 3 decades.
[141] PAL Sch 1061.6: Karl Schöpf, *Letter to E. Maranta. Ifakara 29.01.1956*.
[142] Interview Sr. M.P. Baldegg, 26.01.2010. also *Interview with Sr. Josephata Schürmann, Dar es Salaam, 31.01.2009*.

community propagated the ideal image of the selflessly serving nun as a follower of the example of the biblical Martha.[143] Still, a new category of mission staff, the "lay helpers" enlarged the nursing corps of nun sisters in the mid-1950s. In light of a long organizational debate about non-clerical contribution to the Catholic mission, this was a major change.[144] The local population hardly perceived much of a difference between the two categories, who both strongly identified with Catholicism. The lay-helper nurses had basically the same medical training, but straighter medical careers, and were not bound to the rules and the spiritual rituals of the congregation.

All these nurses still encountered problems in getting registered at that time – as their training did not match the Tanganyikan requirements and Schöpf, in hindsight, was commendatory about the performance of the nurses in the operation theatre, the lab and the hospital in general. Schöpf also saw that many of the nurses were overworked, and sometimes depressed (which he saw as a result of the hard work).[145] The nurses did not all experience this warmth from Schöpf.. Sr. Ruth, who served as a Matron in the early 1960s, felt that the doctor cared little about how nursing was to integrated in the organization of the hospital and the daily medical routine.[146]

There certainly were reasons for conflicts about hierarchies. Although Sr. Arnolda had such a great standing, gendered Church hierarchies were still in place in the mid-1950s. Sisters still wrote only very short letters from Ifakara, and even Sr. Arnolda checked to see if she should have asked Dr. Schöpf to sign even a simple letter asking for hospital equipment for the laundry.[147] When sisters wrote it was often to say "thank you" to the male mission staff, for example, for a typewriter given to the sisters, or to apologize for mistakes or for their ignorance about the handling of cheques, for example.[148] To some degree, these hierarchies came apart from the late 1950s. My interviews showed that many of the sisters were proud of changes at

[143] Sr. Innozentia M. Hürlimann, *Die Missionärin und ihre Arbeit*, in Providentia, 1954, pp. 92-93; P. Hilmar Pfenniger, *Unsere Missionsschwestern*, in Missionsbote der Schweizer Kapuziner in Afrika, 1957, p. 69.

[144] G. Clément, *Femmes laïques au service des missions*, in Missionsärztliche Caritas, 1935; Johannes Beckmann, *Laienapostolat*, in Missionsärztliche Caritas, 1944; Karl Maria Bosslet, *Der Arzt und die Not der Zeit missionsärztliche Gedanken zum Laien-Apostolat*, 1949; P. Joseph Henninger, *Le Laïcat Missionaire*, in Neue Zeitschrift für Missionswissenschaft, 1951. The Pope supported the missions in their openly stated request that lay workers should contribute to the mission, especially in Africa: Papst Pius XII., *Fidei Donum. On the Present Condition of the Catholic Missions, Especially in Africa* (1957), pp. 23-27, 63; P. Hilmar Pfenniger, *Unser Titelbild*, in Missionsbote der Schweizer Kapuziner in Afrika, 1957.

[145] Nun-Nurses interrupted their medical training in order to follow their religious training and entry into the congregation. Also they received their medical training from a sequence of hospitals in Switzerland, rather than just one place. TNA 450/1177: *[file] Registration of Nurses*. For a critical position on the preparation for Africa see: Franziska Löpfe, *Auf sich gestellt*, 2007, p. 61, 64-65. A young nurse like Nina Disler left Africa after about 60 months of service tired and burnt-out. Franziska Löpfe, *Auf sich gestellt*, 2007, p. 71; *Interviews with Karl and Irmengard Schöpf, Zams 23-25.07. 2007*.

[146] *Interview with Sr. Ruth Gasche, Dar es Salaam, 08.02.2009*. The tasks of the matron were regulated in writing in 1963, soon after Sr. Arnolda's death, with the matron in charge of all domestic and nursing tasks, including what today would be called human resources. PAL Sch 1061.6: Karl Schöpf, *Letter to E. Maranta. Ifakara, 12.10.1963*. It was the Baldegg community, i.e. Mother General, who decided that Sr. Ruth was to be the Matron according to Interview *Interview with Sr. Ruth Gasche, Dar es Salaam, 08.02.2009*. The choice also fell on her because she had good skills in English.

[147] PADSM Box 332 Baldegg Sisters correspondence - Bishops Sec: Sr. Arnolda *letter to "Pater Oswin ", n.d.*

[148] PADSM Box 332 Baldegg Sisters correspondence - Bishops Sec: Sr. Arnolda *letter to "Pater Secretär"*; PADSM Box 332 Baldegg Sisters correspondence - Bishops Sec: Sr. Magda *Letter to P. Oswin. Ifakara, 07.01.1955*.

that time and in the wake of the Second Vaticanum, when they liberated themselves from some of these 'old' hierarchies and took matters more openly in their hand throughout the Mission.[149]

## The colonial issue: Race

Race still loomed large, and to some degree became accentuated with the new hospital.[150] A contentious issue was that of the missionary purpose of the hospital. Schöpf saw the financial potential of treating non-African patients, and actively recruited private patients for the hospital. When he could offer his surgical skills to them plus the care provided by white nurses – working for small or no salaries – the financial potential was substantial.[151] Soon private patients, notably British, Greek, and Indian, were lodged in the main hospital building, although not in large numbers. The fact that the hospital now cared for these patients made the sisters nervous. Catering for non-Africans complicated nursing: the sisters were concerned that this was not the calling for which they had left their home country and families, which had been to 'nurse the bodies and souls of the poor natives', besides, Africans were afraid that they were being pushed out of the new hospital. The additional income was welcome but did not easily mute the doubts.[152] Sr. Alfonsina, who now worked in the new hospital, in the operation theatre in charge of anesthetics and caring for private patients, explained:

> "at the start, it was not easy. Often I remembered what you told me some months ago. Yes, I want to do my duty, wherever God wants me to do it. I would really love to spend my strength and health on serving the poor Africans, but it is not the will of God."[153]

Sr. Arnolda, on the other hand, seems to have supported Schöpf's approach and even volunteered to cook for the private patients.[154]

Race, not least, played a role in relations within different segments of the staff. It was not the only factor though, as we have already seen: gender played a role; whether a sister was a nun, or a lay helper. Later, whether workers were employed on government or mission

[149] Personal communication Sr. Sandra Stich, Dar es Salaam March 2008.
[150] I have argued in two unpublished papers read at Conferences in Berlin and London that it certainly became articulated in new ways in the age of national states and international development cooperation in medicine: Marcel Dreier, *„The Africanisation of St. Francis Hospital". The perception and construction of difference in medical development practice in a rural Tanzanian setting, 1950-1990* (paper presented at the Third European Congress on World and Global History. London: LSE, 14-17.04.2011, 2011); Marcel Dreier, *„Die Afrikanisierung eines Spitals". Aus der Praxis medizinischer Entwicklungshilfe im ländlichen Tansania der 1970er und 80er Jahre* (paper presented at the 48. Deutscher Historikertag, Berlin, 29.10.2010, 2010).
[151] PAL Sch 1061.6: Karl Schöpf, *Letter to E. Maranta. Ifakara, 17.07.1957*; *Interview with Sr. Bernardina Allenspach, Dar Es Salaam, 02.03.2009*.
[152] *Unsere Missionsschwestern*, in Providentia, 1957; Sr. Pankratia Stumpf et al., *Unsere Missionsschwestern*, in Providentia, 1957. Schöpf also did some fanciful gynecological operations that hardly found the advocacy of Catholic nuns (personal communication by a medical doctor who had worked in Ifakara, 04.01.2012).
[153] PADSM Box 332 Baldegg Sisters correspondence - Bishops Sec: Sr. Alfonsina *Letter to P. Alfred. Ifakara, 04.08.1957*. Compared to sisters who were doing service, for example, in South African missions at the time, and often catered exclusively to white patients, nuns in rural Tanganyika could be quite sure they would actually work with African patients. For a description of South African racially divided institutions, see Sr. Mariette Gouws, *All for God's People*, 1977, e.g. chapter 37.
[154] Sr. Pankratia Stumpf et al., *Unsere Missionsschwestern*, in Providentia, 1957.

contracts, was a source of differentiation. Debates about nursing standards and care ethics amalgamated ideas of class, race and culture into a work environment which was certainly shaped by a great amount of intercultural exchange, to use the parlance of today, – but with leaning towards the upholding of hierarchies known from colonial times.[155] But criticism – at least in the sources – was not expressed in the colonial terms (a paternalist patience towards the "the slow pace of work inborn to the African"[156]) as "supervision" increasingly became the term for hierarchical relations amongst professionals.[157] Seeing the large number of medical staff with a German-language background, it is not surprising that much of the medical work and hospital management was based on Swiss and Austrian German dialects for some time to come, even though the official medical language in the early 1960s was English especially with students from the attached medical schools but even with the better trained nursing staff.[158] If we take into account the historical situation of vociferous claims for Africanization, especially in the administrative and economic centres of Tanganyika, there is little to be heard about this in the St. Francis Hospital in the 1960s. Just how far the hospital remained untouched by the political power dynamics of decolonization is exemplified by the fact that Schöpf decision to exclude from the hospital the representatives of the trade union sent in from Morogoro was quite uncontested.[159]

## Doctors

We have already seen that Schöpf was not the only doctor in Ifakara in the 1960s. It had however not been easy for him or for the Mission to recruit colleagues. From the mid-1950s, Schöpf and Maranta tried to recruit a second doctor. It was clear that the hospital was going to be too large for a single doctor, and also a specialist in internal medicine (a physician) was needed to complement the surgeon's specialization.[160] In 1956 Schöpf travelled to Europe for

[155] Even professionally trained African nursing staff was sometimes criticized for a lack of training, as for example in the correct judgment of an individual patient's medical condition Sr. Bernardina Allenspach, *Sr. Bernardina Allenspach schreibt aus dem San Francis Hospital Ifakara, Tanzania*, in Missionsärztliche Caritas, 1967. At the beginning however it seems to have even been unclear to many of the staff which training Africans really had and some trained nurses might have been considered as mere assistants by their European colleagues. *Interview with Sr. Ruth Gasche, Dar es Salaam, 08.02.2009*.

[156] Schwester Maria Pia, *Vom Werken und Wirken der eingeborenen Schwestern*, in Missionsbote der Schweizer Kapuziner in Afrika, 1951, pp. 8-9. ("kindness is necessary, yet it must be paired with strictness and a precise knowledge of what can be asked of the [African]", a guide of the Swiss Federal office for Industry and Labour advised Swiss emigrants to East Africa in 1951: Berta Coninx-Girardet, *Britisch-Ostafrika*, 1951, p. 76-77.

[157] "Supervision" remained a contentious issue long into the 1980s: ASML Schachtel_A4_braun/"ganz alte Berichte versch. Länder/SFH Evaluation Hess": Christian Hess, *SKMV: Interne Evaluation des SFH von Dr. Christian Hess, Luzern 01.12.1983 [inkl. Ergänzender Anhang für internen Gebrauch]*.

[158] PAL Sch 1061.6: Karl Schöpf, *Letter to E. Maranta. Ifakara, 15.01.1959*. At some point in time there were 22 Baldegg sisters in Ifakara (not all of them working in the hospital, according to Im Rahmen des Projektes www.humem.ch. Humem et al., *Interview mit Sr. Maria-Paula Wicki. Baldegg 09.09.2009*. *Interviews with Edgar Widmer, Thalwil, 23.10.2008 und 27.10.2008*. In the community of Swiss siters and nurses however it was Swiss German.

[159] *Interviews with Karl and Irmengard Schöpf, Zams 23-25.07. 2007*.

[160] *Unsere Missionsschwestern*, in Providentia, 1957. In 1955 a first attempt to bring a colleague of Schöpf from the Hospital in Zams failed when the process was almost completed: Maranta and Schöpf soon assumed that, just as Schöpf, Dr. W. Would not be 'registered' by the responsible offices in Tanzania.PAL Sch 1061.6: Edgar Maranta, *Letter to C.Schöpf. DSM, 04.04.1955*. PAL Sch 1061.6: Karl Schöpf, *Letter to E. Maranta. Ifakara 08.04.1955*. In 1955 it seemed almost accomplished

training with Dr. Lehner in Lucerne and for vacations in 1956 and 1959 and, in the meantime, a Swiss doctor came to Ifakara as his substitute.[161] In 1959, however, Schöpf had still not found a colleague, although so many were interested in his work in Ifakara.[162] By the end of 1961, St. Francis Hospital finally had become an attractive place for a doctor to work and attracted new and additional doctors, from other places in East Africa. Dr. Peham was another Austrian who had studied in Innsbruck; he left for Tanganyika in 1959 and came to Ifakara via Arusha and Dar es Salaam.[163] Another doctor was recruited from the Catholic mission hospital at Turiani. His transfer exemplifies the institutional drivers at play which made peripheral hospitals less attractive for (most) doctors and which attracted new doctors to Ifakara. Although Turiani was a very new hospital the first and only doctor there left for St. Francis Hospital in Ifakara in the early 1960s where he expected to have much better working conditions. Turiani was left without a doctor and in a difficult situation, yet one that also opened the path to a faster integration into the national health care system.[164] In Ifakara, on the other hand, the increasing number of doctors meant that specialization could develop, and also other factors of scale, like increased presence of doctors, or easy counselling amongst the clinicians could take hold and probably strengthen the quality of clinical services.[165] Swiss doctors came to Ifakara, for shorter or longer periods, and in 1965 the first and only female doctor produced by the Baldegg community came to Ifakara, too.[166] From the mid 1960s the Mission undertook first attempts at starting the careers of future doctors recruited from the Catholic Ulanga, but without much success.[167]

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when a problem of registration (and an impending failure to touch government grants for the second doctor) stopped an Austrian friend of Schöpf from coming: PAL Sch 1061.2 Ärzte verschiedene Anfragen: Heinz Wolfram, *Letter to P. Provinzial. Zams, 19.01.1955*. Other examples: PAL Sch 1061.2 Ärzte verschiedene Anfragen: Olga P. Weber, *letter to E. Maranta. Detroit 01.03.1956*.

[161] PAL Sch 1061.3 Ärzte etc. Verschiedenes: *[file] Dr. Howald*. Dr. Howald. Zb: PAL Sch 1061.6: Karl Schöpf, *Letter to E. Maranta. Ifakara, 10.12.1958*. PAL Sch 1061.6: Karl Schöpf, *Letter to E. Maranta. Luzern, 30.11.1959*. Dr. Diethelm was one amongst the group of doctors connected to Dr. Lehner in Lucern. Dr. Lauber was another who came to Ifakara through this node PAL Sch 1061.6: Karl Schöpf, *Letter to E. Maranta. Ifakara 14.06.1962*. Lehner himself was in Ifakara a couple of times: Rolf Diethelm, *Erinnerungen an Ifakara. Aus den eigenen Notizen (Tagebuch) über meine Tätigkeit in Afrika 1959/1960*, (Altdorf2006), p. 2.

[162] PAL Sch 1061.6: Karl Schöpf, *Letter to E. Maranta. Luzern, 30.11.1959*; PAL Sch 1061.6: Karl Schöpf, *Letter to E. Maranta. Zams, 28.12.1959*.

[163] Peham worked in Ifakara for more than a decade. He married the daughter of Karl and Irmengard Schöpf, but interestingly this did not found a medical dynasty at St. Francis Hospital, as Peham never took the post of medical director.

[164] Majella Lenzen, *Das möge Gott verhüten*, 2009, pp. 73, 81-72.

[165] *Interviews with Karl and Irmengard Schöpf, Zams 23-25.07. 2007*.

[166] Sr. Bernardina came to Ifakara as a general practitioner but retrained as a surgeon in the late 1960s in Switzerland and would then work as the medical director of Huruma hospital in Northern Tanzania. Her dissertation was on surgical treatment for schistosomiasis: Susann Allenspach, *Operative Behandlung urologischer Komplikationen bei chronischer Bilharziose (Schistosomum haematobium)*, 1972. *Interview with Sr. Bernardina Allenspach, Dar Es Salaam, 02.03.2009*. Institutsarchiv Baldegg BIII,7,4: *Chronik Huruma*; Sr. Bernardina Allenspach, *Sr. Bernardina aus dem Huruma Spital berichtet*, in Providentia, 1974; ASML R2T1S2blauO2 Afrika. Tanzania.../Murumba, Moshi: Sr. Bernardina Allenspach et al., *Letters from Huruma Hospital*; PADSM Box 353: *Huruma Hospital: Our Lady of Kilimanjaro*.

[167] They were not successful as the level of the schools in the area did not offer a way to college medical college.DAK folder "archbishop DSM Yan'61-Mei'65": Edgar Bishop Maranta, *Letter to Pater Gallus, Dar es Salaam, 29.05.1965*. PADSM Box 17 - Mahenge 4: Edgar Maranta, *Letter to P. Donat, DSM 23.08.1964*. DAK folder "archbishop DSM Yan'61-Mei'65": Edgar Bishop Maranta, *Letter to Pater Gallus, Dar es Salaam, 29.05.1965*. From the early 1980s many careers of African doctors were built on the St. Francis Hospital.

## The Ifakara Approach at Combating Tuberculosis

Leprosy and Tuberculosis, both bacterial diseases, were treated in specialized and closed institutional settings in the first half of the 20th century, the Asylum for sufferers of leprosy in the colonial tropics and the Sanatorium for victims of tuberculosis in industrialised countries.[168] The treatment of both diseases changed substantially in the 1950s. With the introduction of sulphone treatments ("Dapsone"), the prospects of a cure for leprosy changed for the better. The availability of new chemotherapeutics pushed the Mission towards a major, renewed interest in Leprosy care. In the mid 1950s, it established a new treatment centre in Ifakara, called the St. Vincenz home and, later, Nazareti. This institution was rapidly modernized in the early 1960s and developed into an important centre for the care of leprosy patients in East Africa.[169]

With the introduction of chemotherapy trials on a global scale, the era of the TB sanatoria came to an end in the 1950s.[170] How the sanatorim idea was transformed is a highly telling expression for the way in which medicine and Development were configured in the South in the 1950s and 1960s, when the second epidemic wave of Tuberculosis (TB) rolled through the world and hit the countries in the developing world.[171] In East Africa, TB had become "the priority disease of the 1950s".[172] It was an era, in which, as Sunil Amrith has argued, technological fixes were believed to overcome the social causes for disease.[173] BCG vaccination was pushed in campaigns.[174] Research concentrated on chemotherapy in extra-European sanatoria environments.[175] There were also attempts to establish surgery as a method to treat tuberculosis.[176] All these technological solutions were based in the idea of a modernizing development.

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[168] Some researchers of the history of Tuberculosis have called the period the "era of the sanatoria"Flurin Condrau, *Beyond the Total Institution*, 2010. Christina Vanja, *Heilanstalten*, 2007.

[169]Marcel Dreier, *Wer möchte da nicht krank sein*, 2011; SKMV, *Jahresbericht 1959 des SKMV*, in Missionsärztliche Caritas, 1959. Interview Sr. M.P. Baldegg 26.01.2010. Im Rahmen des Projektes www.humem.ch. Humem et al., *Interview mit Sr. Maria-Paula Wicki. Baldegg 09.09.2009*; Thomas Gull et al., *Die andere Seite der Welt*, 2011, has a chapter on Sr. Maria Paula Wicki; PADSM 153/4: Hieronymus Schildknecht, *Die Entwicklung der Mission Ifakara 1911-1958*; Knud Balslev, *History of Leprosy in Tanzania*, 1989.

[170] IUAT et al., *The Union. 90 years of collaboration and innovation*, 2010, p. 4.With the exception of Packard, whose study is largely limited to the boundaries of South Africa, little historical research has been undertaken into the history of tuberculosis control in Africa. Randall M. Packard, *White plague*, 1989, pp.276-298; Pascal Schmid, *Medicine, Faith and Politics*, 2013, chapter 4. For other parts of the global south seeHelen Valier, *Home in the Colonies*, 2010; Sunil Amrith, *In Search of a Magic Bullet*, in Social History of Medicine, 2004; Christian W. McMillen et al., *Medical Modernization*, in Comparative Studies in Society & History, 2010. M. C. Raviglione et al., *Evolution of WHO policies for tuberculosis control, 1948-2001*, in The Lancet, 2002. Mark Harrison et al., *Disease of Civilisation*, 1997.

[171] Mark Harrison et al., *Disease of Civilisation*, 1997.

[172] John Iliffe, *East African Doctors*, 1998, p. 108; TNA 450/1573/5A: Tanganyika Territory Provincial Medical Officer E.P. et al., *Medical Department. Eastern Province. Annual Report 1955*.

[173] Peter P. Turner, *Presidential Adress. The Physician and the Public Health*, in East African Medical Journal, 1964. Sunil S. Amrith, *Decolonizing International Health*, 2006, p. 157.

[174] On the WHO campaign: George W. Comstock, *The International Tuberculosis Campaign*, in Clinical Infectious Diseases, 1994. Sunil S. Amrith, *Decolonizing International Health*, 2006, pp. 82-83, 151ff; Charles Wilcocks, *An analysis of some recent work on tuberculosis in Africa*, in British Journal of Diseases of the Chest, 1960.

[175] Charles Wilcocks, *An analysis of some recent work on tuberculosis in Africa*, in British Journal of Diseases of the Chest, 1960.

[176] Pascal Schmid, *Medicine, Faith and Politics*, 2013, chapter 4. Flurin Condrau showed how the career of the TB sanatoria made it imperative to have 'relevant equipment for chest surgery" after WWII. Flurin Condrau, *Institutional Career of Tuberculosis*, 2007.

This second wave also linked the world in new ways. Although in comparison with other territories under British administration in Africa, the League of Nations mandate territory of Tanganyika saw comparably important empirical research, the first tuberculosis measures introduced in the 1920s and 1930s were small in scale and hardly linked to the sanatoria movement and the anti-TB campaigns in European countries.[177] Slowly, in the 1950s, in some rural areas, tentative ambulatory and preventive services were put in place, and two specialized TB treatment schemes based on the network of dispensaries in the North and one that seems to have included mission dispensaries in the South of Tanganyika were under way.[178] At the beginning of the 1950s, the WHO argued for the importance of TB treatment and said that hospitals for TB patients should be built in "the simplest and cheapest style" and worked on spreading these interventions globally, leading to a "postwar rush […] linking the world through a common vaccine, a battery of antibiotics, and a knowledge network."[179]

Lung diseases had long been noted by the Swiss missionaries. From their first experiences in Dar es Salaam, the Swiss missionary nuns had reported that 'Schwindsucht' was very prevalent, and they perceived that women were particularly afflicted by 'lung disease'.[180] During WWII, the Swiss doctor Alois Gabathuler looked closely at Tuberculosis and reported a high incidence of TB in Mahenge.[181] Sr. Arnolda observed the young men returning from migrant labour on sisal estates were dearly in need of medical support.[182] Doctors at the new St. Francis Hospital Ifakara were sensitive to the epidemic and endemic health hazards posed by TB. Dr. Diethelm observed that TB was widespread and "patients are in a poor position. The means to cure them properly are lacking."[183] In peripheral places like the Sofi Mission dispensary, missionary nuns from the Baldegg congregation spearheaded an investment in TB work in Ulanga. They added a small TB section with ten beds to their growing dispensary, as well as a verandah where three TB patients could lie outside in sanatorium style.[184] The sisters

[177] For a concise literature review see the Linda Bryder et al., *Tuberculosis and its Histories*, 2010. On early research in Tanganyika see: David F. Clyde, *History of the Medical Services of Tanganyika*, 1962.p. 119-120. Charles Wilcocks, *Tuberculosis in the natives of Tanganyika territory*, in Tubercle, 1935, p. 43.

[178] TNA 450/1614/10A: Tanganyika Territory Provincial Medical Officer E.P., *Medical Department. Eastern Province. Annual Report 1957*. *A Plan for the Development of Medical Services in Tanganyika With Special Reference to the Period 1956/1961*, 1956[?], pp 32-33. In 1958 it was stated: "During the year a great das of attention waas paid to tb wich is without doubt one of the major and most pressing purblic health probems in the Territory." From: TNA 450/1623: Tanganyika Territory Ministry of Health, *Annual Report of the Medical Department for year 1957*. The southern Scheme is mentioned in TNA 450/1563/3A: A. McGregor, *Annual Report Eastern Medical Region, 1954*. TNA 450/HE1636: Tanganyika Territory Ministry of Health et al., *Report to HE the Governor [work of MoH during 1959]*.

[179] *WHO and tuberculosis control*, in Tubercle, 1950. Socrates Litsios, *Third Ten Years*, p. 196. Christian W. McMillen et al., *Medical Modernization*, in Comparative Studies in Society & History, 2010, p. 180-181.

[180] *Das Negerhospital in Simbasi*, in Missionsbote. Missions-Nachrichten der Schweizerischen Kapuzinerprovinz, 1922; *Krankheit und Krankenpflege in unseren Missionen*, in Missionsbote der Schweizer Kapuziner in Afrika, 1924.

[181] TNA 450/1230/7: Alois W. Gabathuler, *Government Hospital Mahenge. Annual Report 1944 [15.01.1944]*.

[182] Sr. Marie-Ruth Ziegler, *Weisse Mama von 5000 Kindern*, in Ite, 1997. Also in Arnolda's obituary in Missionsbote 1,1963 and in Schwester Erika Lischer, *50 Jahre Baldeggerschwestern in Tansania 1921-1971 (manuscript)*, (PADSM/Institut Baldegg, 1971).

[183] PA Diethelm Rolf Diethelm, *Tagebuch*.

[184] PA Diethelm Rolf Diethelm, *Tagebuch*, entry dated 26. 01.1960. Roughly six: Sr. M. Timotheoa et al., *Februarbrief aus Sofi*, in Providentia, 1961.

systematically tested sputum from all coughing patients for tuberculosis bacilli, recorded the results and seem to have treated all positive cases with anti-TB-drugs.[185] The new St. Francis Hospital at first offered only makeshift accommodation for TB patients in slightly segregated temporary huts on the hospital grounds.[186]

It was in Ifakara that the Catholic Church made a large investment into anti-TB work. It was possible because the Catholic missionary movement in Switzerland was about to start an enormous funding campaign for missionary activities – the *Missionsjahr*, later called Fastenopfer – and the Swiss Capuchin mission in Tanzania was one of the major bodies to profit from this. It was decided that the entire collection for the Capuchins was to be spent on a single project: a 130-bed TB hospital in Ifakara as an addition to the St. Francis Mission Hospital.[187] The fact that the project featured as one of the largest of 14 "showcase projects" from across the globe for the *Missionsjahr* certainly helped in setting the pace for the hospital's quick realization. There was a clear message to the Swiss. The Capuchin missionary, Walbert Bühlmann, who was a great reformer of the Catholic mission from the 1960s, wrote about the Ifakara TB hospital, that "this enterprise will be a model and example how home-grown organizations (heimatlich) can rise above themselves and realize their responsibility in the world."[188]

None of those who pushed the TB hospital idea in Ifakara were specialists in current TB control policies.[189] The treatment regime chosen for the Ifakara approach was based on the availability of X-ray facilities in conjunction with the capacity for surgery. A number of reports promised positive results from surgical treatment of Tuberculosis.[190] While the new TB hospital was being constructed, Karl Schöpf met with exponents of Catholic medical missionary internationalism in Europe.[191] He reported from a meeting:

> "Almost all gentlemen knew about Ifakara," he, "and it was presented as exemplary for mission medical work. Only with this kind of hospital establishments, modern in building and organisation, will it be possible to face the future. The old bush-hospitals will go to rack and ruin in the face of rapid developments [in German: unter die Räder der raschen Entwicklung kommen] as soon as medical services in developing countries will be modernized and taken care of by Government. Yet a hospital like Ifakara will be able to keep its Catholic character and its exemplary ethical foundations."

[185] PADSM Box 155 Ifakara SFH 2: A. Ott et al., *Bericht über den Besuch von Dr.med. A.Ott, Delegierter der SVT für Entwicklungshilfe in Tanzania vom 24.08.1969-14.09.1969*. The scientists however never really used this data. Interview with Dr. J.Sobotkiewicz, January 2010.
[186] R. Diethelm, *Das Spital Ifakara*, in Missionsbote der Schweizer Kapuziner in Afrika, 1960.
[187] PADSM Box 153: *Chronica V [Capuchin Mission Ifakara]*. There was much additional funding coming in from Austria: PAL Sch 1061.6: Karl Schöpf, *Letter to E. Maranta. Ifakara 15.06.1961*.
[188] Walbert Bühlmann, *Mustergültiges Tuberkulose-Projekt*, in ite, 1969.
[189] PAL Sch 1061.6: Karl Schöpf, *Letter to E. Maranta. Zams, 28.12.1959*.
[190] Charles Wilcocks, *An analysis of some recent work on tuberculosis in Africa*, in British Journal of Diseases of the Chest, 1960. Charles Wilcocks, *The tuberculosis of the natives of Tanganyika Territory*, in British Journal of Tuberculosis, 1937, p. 231.
[191] On this network see: Medicus Mundi. Edgar Widmer, *Medicus Mundi Schweiz: Dachorganisation für medizinische Entwicklungshilfe*, in Praxis - Schweiz. Rundschau für Medizin, 1973.

Consequently, the doctors present, with at least one of them, Heinrich Jentgens[192] having a strong background in Tuberculosis treatment and notably in developing chest surgery in Germany in the 1950s, concluded that it was now a juncture when Ifakara could start offering specialized services, for example, by leading the TB work in Eastern Africa in a distinctive direction with the creation of "a lung and heart station".[193] The basis for such specialization was that a TB hospital in Ifakara met "European standards in everything".[194]

Dr. Justin Colas from Haiti was recruited to be the doctor in charge of the new TB hospital, and he arrived in Ifakara in October 1962. Colas came from the TB clinic in Merheim/Cologne, where he had worked under Jentgens and Georg Heberer, the latter being at that time a founding figure of experimental surgery in Germany.[195] Colas was a cosmopolitan medical man and "good Catholic". He spoke German, English and French, but not Kiswahili, was married to a white Canadian and also brought his two children to Ifakara. Colas had written his first novel, a social and moral tale of contemporary, middle-class Haiti, back in 1958, and presented himself as a cultured scientist - talented, widely travelled, internationally trained.[196] The cultural and racial politics around Colas's arrival were quite outspoken, and soon divisions appeared between the Swiss Sisters, allied with Schöpf, and Colas on the other hand, who seems to have been highly sensible to questions of racial differentiation and discrimination and was not at all willing to evade a conflict on that issue.[197]

The issue of bush hospital practice and the limits of medical work performed by Africans took centre stage in the ensuing conflict. While Schöpf and the Mission had seen Ifakara as a modern institution in an African context, Colas seems to have disagreed with the vestiges of pragmatic, rural bush-doctor approach that he detected. Dressed immaculately in his suit and tie, Colas ordered that his patients be given white bed sheets – which the Swiss nursing staff considered neither possible nor necessary under the circumstances. Racial politics were also made explicit when the medical director feared he would be overruled by a black doctor who would find it easy to establish links to his 'racial peers' and might circumvent the hierarchy at the hospital. Still, for Schöpf, a strong hospital was the priority and he used his connections with

[192] Heinrich Jentgens, *Über die Tuberkulosebekämpfung in afrikanischen Ländern*, in Lung, 1963. Heinrich Jentgens, *Direkte Elektrographie vom menschlichen Herzen, zugleich ein Beitrag zum EKG bei Lungenoperationen*, in Basic Research in Cardiology, 1960.
[193] PAL Sch 1061.6: Karl Schöpf, *Letter to E. Maranta. Zams 19.12.1962*.
[194] ASTIBS 6/2/6 "S.Francis Hospital": SFH, *Jahres-Bericht 1962 des St. Francis Hospitales Ifakara*.
[195] PAL Sch 1061.6: Karl Schöpf, *Letter to E. Maranta. Zams 19.12.1962*. H. M. Becker, *In memoriam Prof. Dr. Dr. h.c. Georg Heberer 9. Juni 1920 – 21. März 1999*, in Gefässchirurgie, 2000.
[196] PAL Sch 1061.6: Karl Schöpf, *Letter to E. Maranta. Zams 19.12.1962*. Colas' wife was Canadian, and he also brought two children to Ifakara. PADSM Box 153: *Chronica V [Capuchin Mission Ifakara]*. Justin L. Colas, *Port ensablé*, 1970. The book states about Colas' biography: Studied Medicine in Haiti, Montreal, Munich, Cologne, Düsseldorf, Paris. "Divers voyages en Europe, en Amérique et en Afrique, à l'occasion desquels il effectua de nombreux travaux scientifiques."
[197] Archbishop Maranta, a weathered colonial man, was slightly apprehensive of the possibility that a modern young doctor like Colas and his wife would find it difficult to live in the small backwaters town of Ifakara: PAL Sch 1061.6: Edgar Maranta, *Letter to C.Schöpf. DSM, 10.04.1963*.

Miserior, a German Catholic development agency quite similar to the Swiss Fastenopfer[198], in order to find funds to pay for Colas's wage.[199]

Today, the former TB hospital is very much an integral part of the hospital. At that time, however, the TB hospital was seen as autonomous. Dr. Colas was considered the 'boss' of the TB ward, but the exact extent of autonomy was never fully clear.[200] If the General hospital had the exalted aim of becoming a sort of a specialist surgery centre, Colas worked hard in the TB hospital to realize the vision of the specialist hospital for chest diseases, extending beyond TB, and transferred the technology for thoracic surgery from Cologne. The very first operation, roughly six months into the hospital's opening, on a chest patient with an "amoeba abscess in the lung" was, however, a failure. The patient died on the operation table. It could be that Colas had opted to perform this first operation on a 'lost' case or a major emergency, rather than putting the life of patient at risk, instead of opting for an easier case to impress the townsfolk (and the well-off private patients from the East African Coast and as far as Aden). Karl Schöpf had not agreed with the choice of the first patient, yet he did not speak against Colas.[201] The second operation Colas decided to perform was with the help of an African assistant. This plan Schöpf opposed explicitly: he would not agree to the assistance of what he considered a "totally inexperienced" African male nurse as long as there were trained surgeons in the hospital. Schöpf decided he would assist the surgeon himself. In the theatre, Colas told Schöpf to wear one of the green operation shirts "for reasons of discipline", as Schöpf reports it, and Schöpf refused. Such kinds of tension - visible in the operation report compiled by Dr. Schöpf - certainly did not make for a good environment for the operation which, sure enough, also failed badly. The patient lost a lot of blood and, having undergone seven hours of operation, the patient died minutes after he had been rolled out of the theatre.[202]

Schöpf was frustrated. He feared that Colas was not up to the task to turn St. Francis Hospital into the specialized centre for Thoracic surgery in East Africa that he had envisioned. Clearly, the division between the doctors was not about the possibility or appropriateness of a high-tech medical approach in the bush. Both the doctors involved aspired to such a practice. At stake in the conflict was: how to choose the steps to be taken to make the new practice a leading light in Eastern Africa. In the eyes of Schöpf, the patients and theatre team chosen by Colas were not conducive to this aim. Maranta was aware of the many professional and cultural tensions in the medical team at Ifakara. Apart from Colas's good surgical credentials (still supported by the

[198] Urs Altermatt et al., *Vom Missionsjahr zum Fastenopfer*, in Neue Zeitschrift für Missionswissenschaft, 1987. For information on Miserior and the German Aussätzigenhilfswerk which did both Leprosy and Tuberkulosis work see Annett Heinl et al., *Spendenfinanzierte private Entwicklungshilfe in der Bundesrepublik Deutschland*, 2009.
[199] PAL Sch 1061.6: Karl Schöpf, *Letter to E. Maranta. Zams 20.04.1963*.
[200] PAL Sch 1061.6: Karl Schöpf, *Letter to E. Maranta. Zams 16.02.1963*. Before Colas came Schöpf had asked Maranta to state clearly „who is the boss". Later he wished to make sure that the he did not have to take responsibility for medical things at the TB hospital. PAL Sch 1061.6: Edgar Maranta, *Letter to C.Schöpf. DSM, 27.02.1963*. PAL Sch 1061.6: Karl Schöpf, *Letter to E. Maranta. Ifakara, 21.03.1964*.
[201] PAL Sch 1061.6: Karl Schöpf, *Letter to E. Maranta. Ifakara, 14.03.1964*.
[202] PAL Sch 1061.6: Karl Schöpf, *Letter to E. Maranta. Ifakara, 14.03.1964*.

Cologne specialists[203]) things were not easily solved by Maranta because of the fact that in a time of 'Africanization' it was "from a political point of view a most dangerous move to replace a black doctor with a European".[204] Still, in December 1965, Justin Colas and his family left Ifakara after two and a half years of service and most probably without further thorax operations on his list.[205] At this time, all the 'white staff' in the TB hospital was replaced and the only Baldegg sister trained as a doctor, Sister Bernardina (Allenspach) took charge.[206] As Colas' successor at the head of the TB department, however, Sister Bernardina could only devote afternoons to the TB hospital. The TB hospital had thus turned out to be a burden to the Church. It had triggered conflicts on the issue of medical (and racial) hierarchies, unsuccessful operations endangered the good reputation of the hospital and – even though the government paid a grant-in-aid of the TB hospital running costs – it was costly to the Mission.[207] Clearly, further specialization was a difficult path on which to go forward.

TB treatment inside the hospital continued.[208] When, in 1969, a TB specialist from Switzerland visited Ulanga, he found the "prettiest collection [schönste Sammlung] of primary, primo-secondary and early and late post-primary Tuberculosis" in the TB section of St. Francis Hospital and conclueded that "every single European University clinic would envy this clinical demonstration material."[209] TB, however, would eventually become an early venture into district work based on the St. Francis Hospital. In 1968, Sr. Bernardina implemented a large but undocumented vaccination campaign with funds from Switzerland:

> "All the bigger villages of the area have been visited and at least 25% of the whole population was vaccinated. Altogether about 40,000. Since the vaccine by then was finished, Mahenge, Kwiro, Ifakara, Kiberege, Kisawasawa and Kilombero [these were the main population centres in Ulanga] have not yet been vaccinated. Therefore new vaccines have been ordered

[203] Justin Colas is still quite famous with older staff at the hospital for a lifesaving operation he did to a well-know local hunter, a case that even the big Dr. Kalo Schöpf, had seen as a lost one.
[204] PAL Sch 1061.6: Edgar Maranta, *Letter to C.Schöpf. DSM 14.03.1964*. Consequently, for some time, attempts to find another specialist surgeon in Europe came to nothing before Dr. Hofman, who was scheduled to arrive in early 1966, could be found 6. PAL Sch 1061.6: Karl Schöpf, *Letter to E. Maranta. [and R. Geigy] Ifakara, 08.02.1965*. Edwin Hofmann had been intended to come to the Rural Aid Centre as a teacher. Originally from Erstfeld, he had been working as a surgeon in Solothurn and since 1954 at the Benedictine Mission hospital in Ndanda, and was said to be a "Lung specialist" (Walbert Bühlmann, *Die Schweiz hilft den Entwicklungsländern: Der Beitrag der kath. Missionen*, in katholisches Missionsjahrbuch der Schweiz, 1960.
[205] PADSM Box 153: *Chronica V [Capuchin Mission Ifakara]*. Sr. Sara, *Chronik des St. Francis Mission Hospital Ifakara*.
[206] ASTIBS 6/2/6 "S.Francis Hospital": SFH, *Jahres-Bericht 1962 des St. Francis Hospitales Ifakara*; PAL Sch 1061.6: Karl Schöpf, *Letter to E. Maranta. Ifakara, 10.11.1965*. Sr. Bernardina had been designated as Colas's assistant from the beginning: ASTIBS 6/2/6 "S.Francis Hospital": SFH, *Jahres-Bericht 1962 des St. Francis Hospitales Ifakara*, p. 2. A new doctor who came to replace Colas from Switzerland left Ifakara because of ill health after just 6 months Sr. Sara, *Chronik des St. Francis Mission Hospital Ifakara*.
[207] PAL Sch 1061.6: Edgar Maranta, *Letter to C.Schöpf. DSM, 10.04.1963*. PAL Sch 1060.3: P. Hilmar Pfenniger, *Letter, Sursee? to Dr. Karl Schöpf, 18.12.1963*. PAL Sch 1060.3: P. Hilmar Pfenniger, *Letter to C. Schöpf. 18.12.1963*.
[208] Statistics on the hospital practice are largely missing for the period up to the end of the 1960s. At that time the TB ward was filled beyond the brink. PADSM Box 155 Ifakara SFH 2: St.Francis Hospital Ifakara et al., *Annual Report 1968 for St. Francis Hospital Ifakara*. Let us not forget that overall mortality in the TB ward in the 1980s soared, and was, in 1984 at 20 per cent, that is ten times that of the rest of the hospital, and also higher than the numbers Gabathuler had recorded 40 years earlier for the worst -years during WWII at Mahenge hospital. Compare: John Iliffe, *The African AIDS epidemic: a history* (Athens; Oxford; Cape Town,, 2006)
[209] PADSM Box 155 Ifakara SFH 2: A. Ott et al., *Bericht über den Besuch von Dr.med. A.Ott, Delegierter der SVT für Entwicklungshilfe in Tanzania vom 24.08.1969-14.09.1969*.

> and it is hoped that in February or March 1969 these villages and towns will be vaccinated. [sic!]"[210]

Sr. Bernardina's spontaneous immunization campaigns were frowned upon by the TB experts from the Swiss League against Tuberculosis. Based on contacts with the Capuchin Mission, the League implemented a 'pilot scheme' in Ulanga and turned the region into a major centre for an attempt at TB service strengthening which drew on the international knowledge gained from the global BCG Vaccination campaign, the Madras and Bangalore trials.[211] That the Swiss League became active with its 'development project' in Ulanga was no coincidence. Rather, it was more the result of the ties that Ulanga had to Switzerland, ties that were mediated through the Catholic Mission.[212] The importance of these long-term ties for the history of Swiss Development Cooperation in Tanzania is the subject of the next chapter.

## Conclusion

This chapter has discussed a programme of medical modernization embarked on in the 1950s and extended into the 1960s, based in a hospital and pushed by a mission that was looking towards its reconfiguration as a Church. From inadequate beginnings in the early 1950s, the St. Francis Hospital had become the single most important medical institution in Ulanga by the end of the decade.[213] It was one of the largest building complexes and the largest employers in the region, too, notably for those trained in modern professions. Firmly based on the ideas of modernization, the hospital was a beacon for the social and medical work of the Church which radiated its message not only to those living in Tanganyika but also succeeded in drawing young people from Europe, thanks to the success of this new institution even as the colonial period was coming to a close. The erection of the new St. Francis Hospital was not only about the establishment of a Catholic institution. It also established a particular style of medicine, one that was modern in the sense of modernizing development.

The medicine provided at the new hospital was marked by a contemporary belief in technological fixes and a high standard of treatment, as well as by the energetic focusing of resources on the medical development of this institution – a strategy that continued into the

[210] PADSM Box 155 Ifakara SFH 2: A. Ott et al., *Bericht über den Besuch von Dr.med. A.Ott, Delegierter der SVT für Entwicklungshilfe in Tanzania vom 24.08.1969-14.09.1969*; PADSM Box 155 Ifakara SFH 2: St.Francis Hospital Ifakara et al., *Annual Report 1968 for St. Francis Hospital Ifakara*. (Oct to Dec 1968: 50,000 doses. In an interview with me, Sr. Bernardina estimated that it was 70,000 doses in all that were administered. *Interview with Sr. Bernardina Allenspach, Dar Es Salaam, 02.03.2009*. BAR E2005(A) 1983/18 t.311 Tansania 19: SVT, *Gesuch der [SVT] für die Gewährung von Bundesbeiträgen für eine erweitertes Tb-Bekämpfungsprogramm im Ulanga-Distrikt in Tanzania [evt 31.03.1969]*.

[211] Sunil S. Amrith, *Decolonizing International Health*, 2006.

[212] PA Widmer Edgar Widmer, *Letter to Association Suisse Tuberculose. Thalwil 13.12.1972*. Maranta, having returned to Switzerland did later not follow the project closely. PA Widmer Edgar Maranta, *Letter to E.Widmer, S.Vittore 11.12.1972*. But his contribution and that of the mission in general was acknowledged in a personal dedication by Ott (PA Widmer in der Broschüre: A. Ott, *Widmung in "Kampf der Tuberkulose in Tansania" an E. Maranta*.) and his letter: PADSM box 359: A. Ott, *Letter to P. Donat. Solothurn, 12.1974*; PA Widmer Edgar Widmer, *Letter to Association Suisse Tuberculose. Thalwil 13.12.1972*. Interviews Sobotkiewicz und Widmer. Personal communication Edgar Widmer 22.10.2008

[213] TNA 450 / HE 1701/3A: United Republic of Tanzania Regional Medical ?? Eastern Region, *Annual Report for Eastern Region 1962*.

mid-1960s with new extensions constantly being planned and partly implemented: a leprosy treatment and care centre was established and soon modernized, a large TB section was added to the general hospital, and plans for an obstetric department, a separate out-patient clinic and a nurses' and midwives' training school were projected. Even if it was not a total medical revolution (people had known about hospital medicine before[214]), it is still important to imagine how hospital medicine came to be understood in process of the creation of St. Francis Hospital in new ways. As a medical institution, the hospital quickly propelled itself out of the established norms in Ulanga and in rural areas more generally. As a powerful medical centre, the hospital reached many people's lives and drew them into a bodily and social experience of a quite sophisticated practice of modern medicine. We can assume that the new hospital catered more for the general population, beyond the Christian community, than the mission dispensary had done.

As such, the medical practice at St. Francis Hospital popularized hospital medicine and set standards even as it made modern hospital services with a metropolitan touch accessible and comparatively 'normal' in the rural situation of Ulanga. The accessibility of hospital care rose considerably with the establishment of the St. Francis Hospital both in the Ifakara and in Ulanga in general, because for many the new hospital was better placed geographically than the hospital in Mahenge and it doubled the number of hospital beds available in the district (and it also doubled the entire capacity of Capuchin mission medical work in Tanganyika).[215]

The establishment of this hospital also meant that important structural elements of the health system were institutionalized. We have also witnessed how issues were installed as institutional conflict lines within the St. Francis Hospital in this period of its making. Apart from the financial side of the enterprise, there were conflict fields about staff and its professional relations and about the specialization of medical services. The medicine at the hospital was not only marked by the presence of surgeons. It also included a substantial number of other professional staff, African and European, and it attracted new outsiders to Ifakara and thus became a driver of medical professionalization – and popular views on professionals in Ulanga. Outward conflict of the institution was little developed at the time, however. The religious character of the hospital was hardly disputed; nor was its political status. Surprisingly, no one seems to have challenged the role of the hospital in the health system. Let us stick with the last point for a moment. The establishment of St. Francis Hospital meant that a fair amount of centralization was happening. Ifakara sucked up the resources for medical mission to a large degree, and it would continue to do so with the resources of the health system more generally. In general, the hospital was not overly interested in the rest of the district during the period under

[214] Alois Gabathuler for example was still well remembered in Mahenge in 2010 for his surgery. Interview with Ally S.J. Lungombe, Mahenge 19.05.2010.
[215] SKMV, *Jahresbericht 1955 des SKMV*, in Missionsärztliche Caritas, 1955, p.5.

discussion here and it seems that there was absolutely no interaction with the Native Authorities dispensaries.[216] Neither was there much attempt from the side of Government, be it colonial or post-colonial, to have an influence on the hospital. The opening by the Governor shortly before *Uhuru* symbolizes the late colonial legacy and how the institution remained under the firm control of the Swiss Capuchins and their new medical staff of doctors and nurses from the central German speaking parts of Europe, who also contributed a substantial part of the funding.[217] Still, this late colonial set-up had its potential, both as a purveyor of social welfare and medical services as well as in its abilities to connect well with the world beyond the Mission. It could do so, not because the hospital was the source of new practices that embodied and animated the nation (with African control over the central institutions of development and welfare), but because it realized the material dreams and promises made by the late colonial powers. These would become the promises of the developmentalist state, as we have argued in chapter 7.

As Maranta had hoped, the hospital in Ifakara, almost from its beginnings, was a substantial investment which wielded great symbolic capital, both locally and nationally. The Catholic Church elite were amongst the patients of St. Francis Hospital as much as the political elite. In 1959 the Wahehe Chief arrived in a white Mercedes Benz car for a consultation with Dr. Diethelm who had replaced Schöpf for some months. Dressed in his white linen clothing, with a necktie, and choosing Coca Cola as his drink, the Chief made a great impression on the doctor.[218] Soon the post-independence elite would also come to Ifakara at times. In Dar es Salaam, P. Edelwald Steiner observed some of the townfolk saving their money in order to go to St. Francis Hospital for surgery.[219] In April 1961, Julius Nyerere's wife came for a medical treatment, and also used her presence for political organization work in Ifakara.[220] Not much later Julius Nyerere also paid a visit to the hospital in August 1961, shook hands with the nurses and was

[216] In 1962 theoretically a network of all the Capuchin Mission's 21 medical stations, of which 6 were run by European sisters. ASTIBS 6/2/6 "S.Francis Hospital": SFH, *Jahres-Bericht 1962 des St. Francis Hospitales Ifakara*. Even where the Mission Hospital structures assisted the peripheral health posts it meant that it controlled flows of drugs and to some degree of staff. Sr. Sara, *Chronik des St. Francis Mission Hospital Ifakara*. Rolf Diethelm, *Erinnerungen an Ifakara. Aus den eigenen Notizen (Tagebuch) über meine Tätigkeit in Afrika 1959/1960*, (Altdorf2006), p.4. Schöpf observed a series of faulty treatments in the dispensaries: *Interviews with Karl and Irmengard Schöpf, Zams 23-25.07. 2007*. A unique report on the situation in the dispensaries at the time is: PADSM Box 155 SFH 1 -1-: Edgar Widmer, *Medizinische[?] Aussenstationen in der Diocese Mahenge. Besuchsbericht vom 11.1964*. PADSM 172/kisawasawa: *Kisawasawa [1952/1953]*.

[217] The financial reports of the hospital are not entirely transparent as to the income produced from Mission/Church, from Government sources and from patients. Desax claims, and he certainly had good sources that in the years 1966-68 the Government contribution was between six to ten per cent only: Eduard Desax, *Entwicklungshilfe*, 1975, p. 139-140. Based on the annual financial reports, it seems as if Government might have contributed about one fifth of the income in 1968. The overall trend was that the weight of the Mission contribution in the total budget became smaller over the years. PADSM Box 155 Ifakara SFH 2: St.Francis Hospital Ifakara et al., *Statement of Account, SFH 01.01.1968-31.12.1968; Budget 1969*. In 1968 the Hospital board also noted that the hospital management had underestimated the government contribution: St.Francis Hospital Ifakara et al., *Minutes of the third meeting of the 'Board of Governors' SFH, Ifakara 30.07.1968*, (PADSM Box 155 Ifakara SFH 21968).

[218] Sr. Sara, *Chronik des St. Francis Mission Hospital Ifakara*; Rolf Diethelm, *Erinnerungen an Ifakara. Aus den eigenen Notizen (Tagebuch) über meine Tätigkeit in Afrika 1959/1960*, (Altdorf2006), p.4.

[219] Personal information by P. Edelwald Steiner, Luzern, 2.12.2010.

[220] PADSM Box 153: *Chronica V [Capuchin Mission Ifakara]*.

led through the hospital by Dr. Schöpf.[221] The hospital used this reputation in order to make propaganda in Switzerland. Schöpf reminded the Swiss audience that the reports of 'important' patients were not representative of the general work done at SFH, but he nevertheless liked to reference all kinds of officials, groups of doctors etc who agreed that the St. Francis Hospital was an outstanding hospital in East Africa.[222]

Maranta now steered the medical work of the Mission into the field of Development activities, and into a kind of a Swiss Development front of church people and scientists in Ulanga. The manner in which Maranta had supported Schöpf's pro-science initiative with the Swiss Tropical Institutes Field Lab is an indicator for the changes that had taken place in the decade since Maranta's rift with the Gabathulers in Mahenge. Now the ties with science and government counted in a major way. This move would prove enormously fruitful in the institutional and medical development of the St. Francis Hospital and helped to sustain the institution for the rest of the 20th century. The next chapter will look how the engagement of the Mission with the hospital fed back to Switzerland as it looked for its place at the global table and how this in turn established the base from which further growth, or at least sustained support from actors old and new, would flow towards Ifakara and the St. Francis Hospital itself.

[221] PADSM Box 153: *Chronica V [Capuchin Mission Ifakara]*, entry for 09.08.1961. Nyerere visited again, for example 29.10.1969

[222] PAL Sch 1061.6: Karl Schöpf, *Letter to E. Maranta. Ifakara 25.01.1956*. PAL Sch 1061.6: Karl Schöpf, *Letter to E. Maranta. Ifakara, 17.07.1957*.

# Chapter 9 The Transition: Development Cooperation Arrives

After the Second World War, Switzerland embraced a new doctrine of "solidarity" with reconstruction in Europe and with cooperation for development through international and bilateral development. In this way the Swiss nation attempted to insert itself into the Cold War global political system of nation states.[1] In Switzerland this period was "full of tensions between stability and dynamic", and as we shall see, also a time of change in Swiss Catholicism which saw 'epochal' changes in the culture of Catholic life in Switzerland.[2] From a mission medical perspective the war had severed ties between the mission field and Switzerland, and it had impacted heavily on institutions in Germany.[3] Once the war had ended, missionaries - and not least amongst them mission doctors - could begin to travel from Africa to Switzerland where they made propaganda for their cause in person. The Swiss Association for Mission Medicine welcomed a series of guests from East Africa who gave talks on practical aspects of medicine in the mission.[4] The mission propaganda projected images both old and new. In the eyes of the missionary observer, post-war Africa faced new challenges and Christianization came to mean that the African was to be raised from paganism at the same time as he was to be saved from Communism. Mission medicine was presented as "almost the sole

[1] This kind of 'development' is often linked with an era of development initiated by a speech by US President Truman: Harry S. Truman, *Inaugural Address, Thursday, January 20, 1949*; Arturo Escobar, *Encountering Development*, 1995, p. 3-4; Wolfgang Sachs, ed. *Development Dictionary*, 1992, pp. viii, xvi; Karin Fischer et al., *Entwicklung - eine Karotte, viele Esel?*, 2010. For the Swiss side of this era see: Albert Matzinger, *Anfänge*, 1991, especially pp. 11-16; Daniel Speich Chassé, *Verflechtung durch Neutralität*, 2012, in particular pp. 230-231. René Holenstein, *Was kümmert uns die Dritte Welt*, 1998, pp. 29-34. Jon A. Fanzun, *Die Grenzen der Solidarität. Schweizerische Menschenrechtspolitik im Kalten Krieg*, 2005, pp. 61-64. Marc Perrenoud, *Guerres, indépendances, neutralité et opportunités*, 2005. Monica Kalt, *Tiersmondismus in der Schweiz*, 2010, pp. 218-219. Lukas Zürcher, *Schweiz in Ruanda*, 2014, pp. 107-117. Sara Elmer, *Postkoloniale Erschliessung ferner Länder*, 2012, p. 249. Switzerland was a founding member of the WHO.

[2] Jean-Daniel Blanc et al., *Achtung: die 50er Jahre!*, 1994, p. 9. Swiss historiography considers the 1950s as a specific period. See Jakob Tanner in the same volume. Peter Hersche, *Agrarische Religiosität*, 2013.

[3] The mission medical training Institute in Würzburg and many of the missionary propaganda publications were crushed during the war: SKVMF, *Missionsärztliche Fürsorge (Jahresbericht)*, in Missionsärztliche Caritas, 1945, p. 52.

[4] SKVMF, *Jahresbericht des Vorstandes*, in Missionsärztliche Caritas, 1947. Printed in Kunibert Lussy, *Die Medizin im Dienste der Mission*, in Missionsärztliche Caritas, 1948. Walbert Bühlmann, *Review: Missionsärztliche Caritas*, in Neue Zeitschrift für Missionswissenschaft, 1949. Friedrich Kürner, *Jahresbericht 1949/50*, in Missionsärztliche Caritas, 1950.

means by which Christianity can penetrate foreign heathen territory" in a time of the great battle against Communism which was to be decided in Africa, a continent that was presented as undergoing rapid change.[5] An alarmist discourse enlisted the Swiss in a fight against poverty, new and old forms of paganism, and in the making of global history. It depended on everyone, "on you too!", whether Africa was to become Christian or Communist.[6]

Pragmatic tools and approaches were needed which related directly with the current political situation and discourses. These tools needed not be new ones, however. Missionary work had been presented as the foundation of a well-managed modernization and the root and source of development in the early 1950s:

> The many buildings, the elaborate roads, the many trained masons and bricklayers, the teachers, [...] and the hospital [of Arnolda] all testify to the fact that it had been the Catholic missionaries, which had brought, with many a sacrifice, religion, culture and civilization to the local people and who have made Ifakara into what it is today.[7]

In the early 1960s this kind of discourse was taken up in Switzerland in order to "re-invent" missionary *Kulturarbeit* as Development aid into what can be termed Development *'avant la lettre'*.[8] This chapter traces the birth of this idea, which appears like a piece of simple propaganda aimed at the Swiss audience, explaining to them how the Mission represented Switzerland's helping hand in the South, with the heartwarming example of all that had been made possible in Tanganyika. We examine how the articulation of the idea within local (mission) discourse in Tanganyika reinforced the transnational engagement between Switzerland and Ulanga, and how it reproduced the idea that mission had to contribute to local development.

This chapter discusses the reconfiguration of mission charity into Catholic development aid. It first looks at the reconfiguration of mission in Switzerland as a transnational enterprise in the late colonial period. We then turn to medical development ideas in the early years of independence in Tanganyika and look at how these plans were configuring the nation (state) and – through the lens of a very detailed case study about the deployment of Swiss doctors in the framework of bilateral development cooperation at the state level – how Switzerland interacted with the new nation. Although the history of the Rural Aid Centre in Ifakara has been recently presented, we need to look at this institution again, as it partnered the medical work at the St. Francis Hospital and was fundamental for the making of Ifakara into a hub of health-related institutions.[9] The Centre was a vital part of the process of interaction through which Ifakara

[5] Friedrich Kürner, *Jahresbericht 1949/50*, in Missionsärztliche Caritas, 1950, p. 35. Walbert Bühlmann, *Die farbigen Völker*, in Katholisches Missionsjahrbuch der Schweiz, 1957. In 1955 Bühlmann authored a series of articles in the Missionsbote on "The New Africa", e.g. on education, political and race relations: P. Walbert Bühlmann, *Vom neuen Afrika [Neue Erziehung]*, in Missionsbote der Schweizer Kapuziner in Afrika, 1955. Other articles in the series discussed housing, dressing, and even food.

[6] *Die Würfel fallen!*, in Missionsbote der Schweizer Kapuziner in Afrika, 1955; Dieter von Schrötter, *Schweizerische Entwicklungspolitik in der direkten Demokratie*, 1981, pp. 42ff.

[7] Pater Hieronymus Schildknecht, *40 Jahre Mission Ifakara*, in Missionsbote der Schweizer Kapuziner in Afrika, 1952.

[8] See introduction and my discussion of, *inter alia*, of Albert Matzinger, *Anfänge*, 1991; Monica Kalt, *Tiersmondismus in der Schweiz*, 2010, pp. 195, 199-203; Jörg Weidmann, *Ursprünge der schweizerischen Entwicklungshilfe*, 1993.

[9] Lukas Meier, *Swiss Science*, 2014, pp. 137-143, 184-191.

became a focus of medical development cooperation, and a pedestal for private Swiss engagement in the development of the Tanganyikan nation. It also helps us, together with other institutions and organizations we look at in this chapter, to understand how Development was designed at the time. The *mélange* of private bourgeois and nationalist motives in Switzerland produced an environment in which the Mission could re-invent 'Kulturarbeit' into Development.

## The Reconfiguration of Mission in Switzerland

The St. Francis Hospital was not an institution isolated in Ulanga. On the contrary, its existence was enmeshed with Switzerland not only because of the material and personal resources it ran on, but also because such African experiences shaped the mission movement in Switzerland and the history of development knowledge and popular support to development aid. With a hospital like the one built in Ifakara, the Mission filled its propaganda in Switzerland with images of their practical action. Not long into the building of the hospital, Dr. Schöpf and a Capuchin brother shot a documentary film entitled "*The Bush Doctor*" about mission medical work in Ulanga.[10] The film of roughly 50 minutes' length was officially presented in Fribourg in 1955, most probably by Walbert Bühlmann, who then took it on a tour in Switzerland.[11] The film showed the doctor in action in the bush, and the foundations of the future hospital buildings. The film projected a vision of health care in the area, a reality in the making. The narrative was about a new departure, but the images it presented were not quite novel. The film explained how the doctor worked in the huts first and then moved his practice into an operating theatre in a hospital. Representing the progressive nature of medical practice was a reconstructed scene depicting the operation on a broken leg with the aid of an intra-medullary nail Schöpf had brought from Europe. These public presentations sought to raise donations for a Catholic hospital along the lines of the one run by Albert Schweitzer.[12]

The man who presented the film about the mission hospital in Ifakara in Switzerland was Walbert Bühlmann. Bühlmann was a Capuchin trained as a missiology expert.[13] He spent most of his comparatively short period as a missionary in Africa in the early 1950s in Ifakara, and was involved in the establishment of the leprosy settlement Nazareti.[14] Bühlmann came back to Switzerland in about 1954 and began to teach at the University of Fribourg on the issue of the

[10] PAL Sch 1061.6: Karl Schöpf, *Letter to E. Maranta. Ifakara 25.01.1956*. The copy of the film I saw was a DVD copy held by Karl and Irmengard Schöpf. A film copy was also held at PSKO in 2009 but has since then probably been moved to PAL.
[11] PAL Sch 1061.6: Karl Schöpf, *Letter to E. Maranta. Zams 16.05.1956*. PAL Sch 1061.6: Karl Schöpf, *Letter to E. Maranta. Zams 20.07.1956*.
[12] The information about Bühlmann's talk from: Interview and film viewing in the company of Karl Schöpf, July 2007 in Zams.
[13] Walbert Bühlmann, *Christliche Terminologie*, 1950.
[14] Schwester Erika Lischer, *50 Jahre Baldeggerschwestern in Tansania 1921-1971 (manuscript)*, (PADSM/Institut Baldegg, 1971), pp. 54-58. *ite nachrichten*, in ite, 2000; Maria-Paula Sr Wicki, *Lepradorf Ifakara*, in ite, 1971.

"social question" in the African missions in particular.[15] He eventually became a great spokesperson of missionary development cooperation, and of a modern, cooperative approach to mission and mission science.[16] Bühlmann's discourse in the 1950s was a typical expression of the discourse in Capuchin Mission propaganda in Switzerland, and from this baseline we can follow the re-configuration of the missionary engagement as Bühlmann anchored his missiology in a more equal and democratic solidarity with Christianity in the global South.[17] It was a discourse shaped by Bühlmann's exposure to a specific discourse in Tanganyika. Bühlmann's experience in Tanganyika therefore was not only a view of hectic modernization in Africa, and fearful Cold War discourse about Communism, but it was most of all a discourse steeped in a consciousness about the need to build modern Catholic social institutions that were relevant to the emerging nation and adapted to political discourse in Tanganyika.

At the same time, the Catholic base of mission in Switzerland was transformed. Never had the Capuchin community been more numerous than in the early 1960s.[18] It found itself in a time of 'epochal change' that saw the end of the 'late baroque moral culture' of rural Catholic society in Switzerland, which changed the base for the convents and the mission, from the kind of donations (increasingly cash-oriented) to the carriers of the Church (increasingly 'lay') and the lifestyles of Catholics who engaged in support of the Mission.[19] The mission movement in Switzerland thus happened in an environment of substantial transformation of Catholic life – which changed the idea of the congregation and especially of mission into something much more grounded in laic live.[20] A number of changes in relation to the structure of mission happened in parallel at this time. As the almost absolute authority of the priestly/church hierarchy loosened and the near monopoly of clerical organizations in mission fell, a sort of 'mission spring' based on the urgency of the need to act in Africa seemed to take hold of Swiss Catholics. The reproduction of the missionary movement through propaganda was still based on events such as travelling exhibitions, which were now not only on a greater scale but, increasingly, an activity of the Church and not just of mission organizations. Missionaries like Bühlmann produced an exhibit called "Messis" in 1955 which pushed missionary activity into the everyday communication of the Church. It was their expressed objective to make missionary work a public

[15] Johannes Beckmann, *Die katholischen Schweizermissionen in Vergangenheit und Gegenwart*, in Studia Missionalia, 1956, p. 153.
[16] Walbert Bühlmann, *Überraschungen meines Lebens*, 1994; Al Imfeld, *Auf den Strassen zum Himmel*, 2013. p. 144-1486 Walbert Bühlmann, *[Editorial]*, in ite, 1965; Urs Altermatt et al., *Von der Messis zum Missionsjahr*, in Neue Zeitschrift für Missionswissenschaft, 1987, fn. 16. Donat Müller, *Missionar order Kapuziner*, 1997; kipa, *Schweizer Kapuziner Walbert Bühlmann fast 91-jährig gestorben*, Katholische Internationale Presseagentur, 16.05.2007.
[17] Walbert Bühlmann, *Mission - Ende oder Wende?*, in Katholisches Missionsjahrbuch der Schweiz, 1969.
[18] Peter Hersche, *Agrarische Religiosität*, 2013, p. 144n179.
[19] Peter Hersche, *Agrarische Religiosität*, 2013, pp. 9, 384-390, 146-387. Vatican II was an accelerator of this process, but not its source: Pierre-Yves Zanella, *Katholische Jugend im Oberwallis, 1900-1970*, 2000, pp. 165-166. For an example how these changes translated in the basis of Swiss Catholicism see: Regula Wind, *reine Töchter - starke Mütter*, 2008.
[20] Urs Altermatt et al., *Neues Missionsbild am Ende der fünfziger Jahre*, Vaterland, 22.09.1984. Urs Altermatt et al., *Von der Messis zum Missionsjahr*, in Neue Zeitschrift für Missionswissenschaft, 1987.

affair at a time when thinking became global.[21] In an event like Messis, the work of the mission became the national contribution in a global world of nations: Messis was presented as a "colourful army parade" of the Swiss in a "time of decolonization", a time when Switzerland was – more than ever – called to contribute to the mission enterprise.[22]

As can happen in times of transformation, the old and the new were assembled in complex ways. In the 1950s, Swiss children would appear in 'blackface' to collect money for the mission to help make the souls of African children "shining white".[23] The missionary departure of the 1950s had an anti-modernistic side as well: the recruitment of young missionaries was incorporated into a traditional message to parents about the importance of the Catholic family and "what begins at the bosom of the mother shall blossom in heathen lands".[24] Such arguments included the open criticism of Catholic families who acquired a materialist orientation or did no longer maximize family size – which meant that there was a lack of supply of new members for the congregations.[25] On the other hand, it was not secular critics but the Mission itself which raised the need for a realistic perspective, of which the "stories of lions, palm tree orchards and lovely fuzzy-wuzzies [*Krausköpfe*]" were but a snippet at best.[26] A realistic view of mission work urged investment in social work in order to prevent proletarianization. One needed, Walbert Bühlmann wrote in 1959, to see the lesson of history in the West, where the masses had turned away from the Church, making it necessary to engage actively in the struggle against Communism.[27] In the eyes of the Catholic Church, welfare issues in Africa needed urgent addressing.[28] The Swiss Catholic Association for Mission Medicine was at the forefront of those who pointed out the material questions that needed to be answered in Africa.[29] In the eyes of this important Swiss missionary medical organization, the "weariness of donors" in Switzerland was a factor that put the prospect of a African Mission Spring in peril. The Association argued, that medical work was a particularly important case in point, because these services were so expensive to provide.[30] But again, change did not come without friction. As mission specialists learnt from their experiences in the South that the training of missionaries had to be adapted to

[21] Walbert Bühlmann, *Vom ersten Schritt zum zweiten*, in Katholisches Missionsjahrbuch der Schweiz, 1956.
[22] Red., *Einführung*, in Katholisches Missionsjahrbuch der Schweiz, 1955.
[23] *Für die Neger Neger werden!*, in Missionsbote der Schweizer Kapuziner in Afrika, 1951. My own mother, born in 1948, remembers having herself collected donations for the mission in this way during her childhood in the area of Altdorf (where there was also a Capuchin monastery).
[24] *Im Schoss der katholischen Familie...* in Missionsbote der Schweizer Kapuziner in Afrika, 1952. "Im Herzen der Mutter muss beginnen, was blühen soll im Heidenland " This sentence played on a popular quote of the protestant national poet Jeremias Gotthelf ("at the homestead must begin that which shall blossom in the nation/fathers' land").
[25] *Ich werde Missionar/Das hat uns gerade noch gefehlt*, in Missionsbote der Schweizer Kapuziner in Afrika, 1955.
[26] Walbert Bühlmann, *Die farbigen Völker*, in Katholisches Missionsjahrbuch der Schweiz, 1957.
[27] Walbert Bühlmann, *Die farbigen Völker*, in Katholisches Missionsjahrbuch der Schweiz, 1957.
[28] In 1959 the Pope declared that welfare was a privilege which not just of a few but all countrie should enjoy, and until this was achieved there was a "large field for activities of the international organizations." *Katholische Kirche und Krankenpflege*, in Providentia, 1959, p.6.
[29] Beilage zu Missionsärztliche Caritas 1955 SKMV, *Werte Missionsfreunde!*
[30] Friedrich Kürner et al., *Jahresbericht 1954*, in Missionsärztliche Caritas, 1954; Friedrich Kürner, *Jahresbericht 1951/52*, in Missionsärztliche Caritas, 1952.

life in the field, the institutions in Europe often failed to undertake the necessary reforms.[31] Conservative values and organizational principles in the convents made for some of the graduates experiencing an opening divide between society and the order in the religious organization.[32]

The missions were, however, quite successful in recruiting a new generation of people for mission work in Africa. New staff was called "on deck" of the Mission as "heroines in the big, wide world", who would bring – "as true Eidgenossen (oath takers)" – honour to both Church and the Swiss nation.[33] The presence of missionaries from Africa in Switzerland during their furlough reinforced the message. Edgar Maranta spoke motivationally to the future sisters in Baldegg, who now met many of their elder sisters of the congregation.[34] Sr. Prudentia Waldisbühl who had worked with Dr. Gabathuler in Mahenge and also Sr. Arnolda from Ifakara came for a long holiday in Switzerland in the early 1950s, before they all became crucial figures in the new hospital in Ifakara. Even Elias Mchonde, soon to become the first African Bishop in the Capuchin Mission region came to stay in Switzerland for some time.[35] Mchonde, who was not a Capuchin, is the most prominent example of the new breed of local priests who established a relationship not only with missionaries but also with Switzerland and who increasingly became the spokespersons of the African Christians among the Swiss.[36]

Increasingly, the established missionaries now saw new groups of Christians, working alongside them. They knew that with the end of colonialism the Church too had to become an indigenous institution.[37] In Africa they would find that in Mahenge an African Diocesan convent had been started, preparing black sisters for the same fields of expertise for which they laboured.[38] A hospital like the one in Ifakara was crucial for this change. First of all, it was the basis on which a practice of solidarity and development cooperation and transnational Christian

[31] Johannes Beckmann, *Missionarische Schulung*, in Neue Zeitschrift für Missionswissenschaft, 1954, pp. 47-49. See also chapter 8.
[32] Such a divide is openly posited in the 'drop-out' literature of ex-missionary nuns like Majella Lenzen, *Das möge Gott verhüten*, 2009, p. 30.
[33] *Eidgenossen!*, in Missionsbote der Schweizer Kapuziner in Afrika, 1951. A young girls' "road to Africa starts in Baldegg", the mission held. *Was steht ihr müssig da?*, in Missionsbote der Schweizer Kapuziner in Afrika, 1951.
[34] Edgar Maranta, *Professpredigt in Baldegg*, in Providentia, 1950.
[35] *Zurück in die Heimat!*, in Missionsbote der Schweizer Kapuziner in Afrika, 1951. *Die Schwestern von Baldegg*, in Missionsbote der Schweizer Kapuziner in Afrika, 1951. Kunibert Lussy, *Plauderecke*, in Missionsbote der Schweizer Kapuziner in Afrika, 1950. Kunibert Lussy, *Plauderecke*, in Missionsbote der Schweizer Kapuziner in Afrika, 1950. *Abschied von Missionären*, in Missionsbote der Schweizer Kapuziner in Afrika, 1951.
[36] *Aus den Missionen*, in Providentia, 1956. *Interviews with Fr. Callistus Mdai, Kwiro, 16.02.2009 and 19.05.2010*. On the lives of priest in Ulanga see Maia Green, *Why Christianity is the Religion of Business*, in Journal of Religion in Africa, 1995. Green revisited this in Maia Green, *Priest, Witches and Power*, 2003. Note that none of these priests were Capuchins at that time. Elias Mchonde and Gregory Mpanda were the first ordained African priests in the area: Apostolic Delegation Mombasa, *A Catholic Directory of East Africa 1950*, 1950.
[37] *Aus den Missionen*, in Providentia, 1956.
[38] *Ein Blick in das Werken und Wirken der eingebornen Schwestern auf der Mission Kwiro*, in Providentia, 1950. Sr. Grace Shembetu, *Maranta*, 2000. As a congregation Baldegg had decided to support local communities of sisters rather than becoming an international congregation itself. Unlike the Baldegg congregation, with their transdiocesan scope of activity, the Mahenge sisters were a 'diocesan' congregation who fell directly under the Bishop and was to serve the Mahenge Diocese only. For extracts of a biography of an early sister see: Schwester Genofeva, *Wie ich Ordensschwester wurde*, in Missionsbote der Schweizer Kapuziner in Afrika, 1951.

engagement was possible at all. On the other hand, it accelerated change by its hunger for new people. The hospital offered positions for much needed professional staff much faster than the (missionary) convents in Europe were able to recruit and train for Africa. In chapter 8, we have seen how a new generation of sisters and a substantial group of so called 'lay helpers' joined the experienced missionaries in Africa.[39] Messis and the changes in the idea of mission it transported also brought a surge of new people going into mission service abroad, reflecting a movement of lay (non–convent style) Christians, in the post-World War era.[40] In 1958, the "Swiss Catholic Lay Helpers Organization" was started as a specific recruiting agency for missions.[41] These new lay nurses were already awaited in Sofi and in Ifakara, where they soon took charge of the new hospital wards.[42] These openings to lay staff and the way it was recruited nevertheless linked the Mission more strongly with the secular and to the national – not because the sisters were secular but because the presence of these non-convent staff eventually fitted missionary activity much more snugly to the coming era of Development in Switzerland: it was possible to receive Swiss government grants for these non-Church "experts" working in projects like St. Francis Hospital.[43] During the 1960s, staff grants towards these development workers in the mission institutions constituted the major financial contribution of the Swiss state's development cooperation to the mission's medical development work in Ifakara.[44]

The new institutions established in the 'mission field' as well as at the 'mission home base' reinforced each other. Schöpf's documentary about the hospital certainly made a good case for financial contributions to the mission, and once the subsequent achievements were reported,

[39] Only some examples can be noted here: Sr. Columba Baumann arrived in Tanganyika in 1950 and worked in the Mission Dispensary in Sofi for some years before she was transferred to Ifakara because of her training as a sister in the operation theatre. Sr. Pankratia Stumpf left for Tanganyika in 1952 and was quickly requested for the St. Francis Hospital by Dr. Schöpf: *50. Missionsaussendung der Schweizer Kapuzinerprovinz*, in Missionsbote der Schweizer Kapuziner in Afrika, 1952. Sr. Maria-Paula was assigned to take charge of the laboratory and soon also catered for the leprosy settlement Nazareti: Thomas Gull et al., *Die andere Seite der Welt*, 2011, pp. 171-182. Sr. Ruth Gasche arrived in Tanganyika in 1959 and became Matron of St. Francis Hospital after Sr. Arnolda died: *Interview with Sr. Ruth Gasche, Dar es Salaam, 08.02.2009*. Sr. M. Jacinta Dähler, *Baldegger Nachrichten*, in ite, 1972. In 1951 Sophie Kaufmann came to Ifakara as one of the first, if not the first "lay helper". She returned to Switzerland, underwent religious training and joined the sisters in Ifakara again in 1959 where she worked as the hospital manager until the early 1990s *Mutige Frauen*, in Missionsbote der Schweizer Kapuziner in Afrika, 1960. ASML R3T5O8: Ifakara Verein, *Protokoll der GV des Ifakara Vereins vom 07.09.1991, Olten*. "Lay helpers" in the 1950s and early 1960s also were Nina Disler, Maria Marty, Paula Faden, Pia Pfister, Olive Schmid, Louise Kaiser, Franca Gulotti. *50. Missionsaussendung der Schweizer Kapuzinerprovinz*, in Missionsbote der Schweizer Kapuziner in Afrika, 1952; *Abreise der Schweizermissionare*, in Katholisches Missionsjahrbuch der Schweiz, 1953.

[40] A. V. Seumois, *Fonction du Laïcat Missionaire*, in Neue Zeitschrift für Missionswissenschaft, 1951; P. Joseph Henninger, *Le Laïcat Missionaire*, in Neue Zeitschrift für Missionswissenschaft, 1951; Walbert Bühlmann, *Das Schweizer Missionswesen: Bilanz von 5 Jahren*, in katholisches Missionsjahrbuch der Schweiz, 1960; SKVMF, *Jahresbericht 1964*, in Missionsärztliche Caritas, 1964.

[41] BAR E2005(A) 1978/137 t.751.007(4): *file overview: Schweiz. Katholisches Laienhelferwerk*; *Unterm Schweizerbanner in Afrika/Der Arbeiter sind zuwenig*, in Missionsbote der Schweizer Kapuziner in Afrika, 1955.

[42] *Aus Missionsbriefen*, in Providentia, 1953.

[43] BAR E2005(A) 1978/137 t.751.007(7): Arbeitskreis Schweizerischer Jugendverbände et al., *file overview: Schweiz. Katholischer Missionsärztlicher Verein*, in particular letter dated 10.12.1964. BAR E2005(A) 1983/18 t.751-7 (7) Katholische Missionen: DftZ et al., *Notiz an das Programm-Komitee: Finanzielle Beiträge an den Entwicklungs-Einsatz von Angehörigen religiöser Orden.*

[44] Group applications replaced individual ones at the end of the 1960s: BAR E2005(A) 1980/82 T441.3 *Freiwillige privater Organisationen: Good, Therese, 14.02.1930*. BAR E2200.83(B) 1990/26 771.26.3: DftZ, *Antrag Nr 329/69 SFH: Einsatz von vier privaten Freiwilligen*.

the missionary movement was further strengthened. In 1960, an upgraded "Messis" sequel, the "Missionsjahr" [mission year] of 1960 headed by a new "Aktion der katholischen Laien" [the Catholic Lay Action Committee] raised 17.5 Mio CHF during that year, and subsequently developed into *Fastenopfer*, a large Catholic Development Aid organization that came to be a major donor for Catholic projects in Ulanga.[45] For the mission year, the Churches advised missions to present projects which were "contemporary and efficiently supported the mission [...] preferably building projects as these can later be shown in pictures, exemplifying the work of the missions."[46] Ifakara could be presented as this kind of institution on which a new transnational base for the financing of Mission/Church social work could grow. A major product of the mission year was the new TB hospital in Ifakara which added 130 new beds to the hospital. It was a message to the Swiss about the leverage of the mission in development cooperation in a new world order of nation-states. When the construction of the St. Francis Hospital had been completed, it was inaugurated by the Colonial Governor; now the beginning of the construction of the TB hospital in 1962 was marked with a foundation stone which also contained a "Uhuru-Medaille" – a commemorative freedom coin – marking the political independence of Tanganyika on 9 November.1961.[47] Eventually the opening ceremony for the TB Hospital produced many headaches, as it was debated whether the President of the Republic should officially open it, or whether representatives of the Church who had contributed the finances should be take centre stage.[48]

## Bilateral Development Cooperation and the Swiss Engagement in Tanganyika

The founding of the Swiss government development organization and Tanganyikan independence occurred almost at the same time. In 1960, Swiss government development cooperation was formally established with a specific service called the Service for Technical Aid/Assisance and from 1961 the Service for Technical Cooperation, *Dienst für technische Zusammenarbeit* (DftZ - Technical Cooperation Services), under the Foreign Affairs

[45] Urs Altermatt et al., *Neues Missionsbild am Ende der fünfziger Jahre*, Vaterland, 22.09.1984. Bühlmann used the term "Fastenopfer" in 1955 already: P. Walbert Bühlmann, *...und sind doch fröhlich*, in Missionsbote der Schweizer Kapuziner in Afrika, 1955. A comparable activity had been accomplished in Austria in 1956/57 and was a success. Similiar activities also followed in Germany where Misereor became a major donor agency. Erich Camenzind, *Missionarisches Verantwortungsbewusstsein im Aufbruch*, in Katholisches Missionsjahrbuch der Schweiz, 1963, p. 76. Urs Altermatt et al., *Vom Missionsjahr zum Fastenopfer*, in Neue Zeitschrift für Missionswissenschaft, 1987.

[46] StaLu PA 619/17: *Protokoll der Superiorenkonferenz betr. Miss. Schulungswochen. Hotel Union, Luzern 26.11.1959*, p. 7.

[47] PADSM Box 153: *Chronica V [Capuchin Mission Ifakara]*, entry dated 22.06.1962. Sr. Sara, *Chronik des St. Francis Mission Hospital Ifakara*. The hospital chronic also contains a photograph showing the Swiss and – somewhat less prominent – the Tanganyikan flags.

[48] PAL Sch 1061.6: Karl Schöpf, *Letter to E. Mchonde. Ifakara 13.07.1967*. PA Widmer Documents re Evangelizzazione e opere per lo sviluppo: Edgar Maranta, *Letter to E.Widmer, DSM 31.07.1967*. Josef [presumably] Hammerl, *Ein Festtag für Tirol*, Kirchenblatt für Tirol und Vorarsberg, Nr. 36, 03.09.1967. On 02.09.1964 the Minister for Health, D.N.M. Bryceson visited St. Francis Hospital and lauded the establishment of the TB hospital: PADSM Box 153: *Chronica V [Capuchin Mission Ifakara]*. Nyerere visited the hospital in 1961 and the hospital including the TB section in 1969.

Department.[49] The conditions for Swiss development cooperation with Tanzania were good: Switzerland still had no full-fledged embassy in Tanganyika, but it looked like a logical stronghold for Swiss Development Cooperation in East Africa.[50] The 650 Swiss present in Tanganyika at that time were a powerful argument for cooperation with Tanganyika, because these Swiss had "established their unchallenged prestige as pioneers in the country".[51] Indeed, in the mid-1960s, the "Swiss colony" in Tanganyika consisted of about 600 people, of whom more than 250 were missionaries, making Tanganyika the second largest Swiss community in Sub-Saharan Africa after South Africa.[52] Switzerland had some substantial economic interests, particularly in the sisal industry. Tanga in the North-East of Tanganyika rather than Ulanga was the economic hub of Switzerland during the colonial era in Tanganyika.[53] From their diplomatic base in colonial Kenya and London, Switzerland sent out diplomatic missions as cognizance of the prospects for development cooperation with the East African countries which were on their way to full independence. The Swiss diplomats travelled to Dar es Salaam where they also met Bishop Edgar Maranta who conveyed the message that the Mission was a strong base for development aid to Tanganyika.[54]

But was medicine going to be an important field for bilateral Swiss development cooperation? In Tanganyika, as we will see in the following pages, it was indeed, but this was an

[49] I will also use SDC as acronym, and speak of Swiss Development Cooperation, meaning the organization since its start in 1960. The DftZ changed its name into DEH in 1976, and into DEZA, in 1996. Schweizerische Eidgenossenschaft, *Botschaft des Bundesrates an die Bundesversammlung über die Zusammenarbeit der Schweiz mit den Entwicklungsländern (vom 05.05.1961)*, Bundesblatt (Bern1961). For a basic account of the history of SDC see the website of DEZA: http://www.deza.admin.ch/de/Home/Die_DEZA/Die_DEZA_in_Kuerze/Geschichte_der_DEZA (last accessed June 2014) Daniele Waldburger et al., *Im Dienst der Menschheit*, 2012.

[50] The report about these early trips was deliberately delayed for roughly two years because "the situation was changing so fast in East Africa" BAR E2200.83 (B) 1983/27 771.20: Erich A. Messmer, *An die Empfänger des detaillierten und vertraulichen Berichtes über Ostafrika, Bern Anfangs Januar 1964*.

[51] BAR E2003-03(0) 1976/44 t.941.1: A. Däniker, *Bericht über meine Ostafrika-Reise, 1961 [sic! correct: 1960]*.

[52] BAR E2200.83 (B) 1983/27 110.9: H.K. Frey, *[Report on visit to Swiss colonies in Mombasa, Tanga and Arusha-Moshi 13.10.1966-21.10.1966] 24.10.1966*. The peak of Swiss presence was probably at about the same time time: René Lenzin, *Schweizer im kolonialen und postkolonialen Afrika*, 2002. Bühlmann counts 300 Swiss Catholic Missionaries in 1961: Walbert Bühlmann, *Der Beitrag der katholischen Mission zur Entwicklung des Tanganjika [sic!]*, in Schweizer Monatshefte, 1961/62, p. 452. Indeed with well over 200 Swiss members of the Capuchin and Baldegg Mission in Tanzania in 1965, there was a substantial number in Tanzania. *100 Jahre Tansania-Mission. 50 Jahre Schweizer Kapuzinermission*, in ite, 1968; *Schweizer Missionsinstitute: die männlichen Institute. 2. Kapuziner*, in Katholisches Missionsjahrbuch der Schweiz, 1965.

[53] There were five-times as many Swiss in Tanganyika as there were in Kenya, although the latter had a substantially higher number of settlers. Berta Coninx-Girardet, *Britisch-Ostafrika*, 1951, p. 226. Other Swiss investments were "the largest" (sic! according to the Swiss visitor reporting, but really?) coffee plantation of Tanzania in Arusha ("Burka") BAR E2200.83 (B) 1983/27 110.9: H.K. Frey, *[Report on visit to Swiss colonies in Mombasa, Tanga and Arusha-Moshi 13.10.1966-21.10.1966] 24.10.1966*. There were further coffee plantations, e.g. Itimba coffee close to Mbeya. BAR E2200.83(A) B.8.1: WD, *Letter to P.Trappe. 12.05.1964*. In Arusha another Swiss became, in his own terms, the "wheat king of Tanzania": Alfred Adolf Häsler, *Weizenkönig von Tanganjika*, 1980. In 1957 "Amboni", partly run on Swiss capital and personnel operated 6 sisal estates, a cattle farm and a palmoil plantation and by 1966 it produced 20% of the annual sisal production, Tanzania's major export crop, and herded 12'000 head of cattle. BAR E2200.83 (B) 1983/27 110.9: H.K. Frey, *[Report on visit to Swiss colonies in Mombasa, Tanga and Arusha-Moshi 13.10.1966-21.10.1966] 24.10.1966*. Hanan Sabea, *Reviving the Dead*, in Africa, 2001. With more than 40 experts of Swiss nationality working for Amboni, the Swiss colonial society based around Tanga had a Swiss doctor, a Swiss Association, and even a rifle shooting range, where Swiss men would practice, using their Swiss army rifles on Swiss national holiday. BAR E2003-03 (-) 1976/44 t.941.1 Tanganyika: Swiss Consul in Dar es Salaam, *Letter to DftZ. DSM 19.04.1962*. In the Capuchin community there were 17 Swiss army rifles registered, but they had run out of ammunition in their specific caliber: BAR E2200.83 (B) 1983/27 110.8: Donat Müller, *Letter do M. Luy. Kwiro 28.10.1966*.

[54] BAR E2003-03(0) 1976/44 t.941.1: A. Däniker, *Bericht über meine Ostafrika-Reise, 1961 [sic! correct: 1960]*. On the history of Swiss Development Cooperation in Tanzania see: BAR E2005(A) 1983/18 t.311 Tansania Allgemeines: DftZ, *Die technische Zusammenarbeit der Schweiz in Ostafrika: Kenia, Tansania, Rwanda und Burundi. Bern 18.06.1971*.

exception rather than a rule, and this was because of the historical roots the Swiss institutions had in Tanganyika. Tanganyika, however, made a slow start as a development partner for the DftZ and, though for the DftZ in general medical work was specified as an important factor in development, in the first years of the service's existence it did not translate into concrete projects, and would eventually dwindle even further.[55] Only 3.3 per cent of total Swiss funds in development cooperation went into the health sector in 1966.[56]

## Medical development in the service of the national state

With independence, the health system in Tanganyika faced new challenges. Almost immediately, the Government set up a committee, consisting of the crème de la crème of Fabian Welfare experts of the London School of Economics (LSE) under the leadership of R.M. Titmuss, to review of the situation of medical services in Tanganyika.[57] The committee wrote a long report which lucidly discussed the problems of the current situation and the "veritable graveyard of health plans" that the committee found.[58] In matters of rural health and sanitation, the plan drew on WHO recommendations and did not develop a really independent Tanganyikan approach for a health system though it was infused with the sense of a national mission. The

[55] BAR E2200.83 (B) 1983/27 771.20: Erich A. Messmer, *Bericht und Antrag der Schweizerischen Delegation für technische Zusammenarbeit über ihre Erkundungsreise in Kenya, Tanganjika und Uganda, vom 12.01.1961 bis 21.02.1961 [Bern, 12.1963!]*. Lukas Meier, *Macht des Empfängers*, 2014.

[56] BAR E2807(-) 1974/12/66 available dodis.ch/31756: Kommissionen für technische Zusammenarbeit, *Programme de coopération technique 1965-67. Résumé géneral*.

[57] The committee started work in 1961: African Medical and Research Foundation et al., *Health Services of Tanganyika*, 1964. On the authors and their Fabianism see: David Piachaud, *Fabianism, Social policy and Colonialism*, 2010, particularly p. 136. Richard Morris Titmuss himself was a professor of Social Administration at the LSE from the 1950s to 1973, and an influential advisor to the British Labour party, and (in the words of Sir Edmund Leach) 'the high priest of the welfare state", for a short bio of Titmuss probably produced for a Titmuss Commemorative Conference held at LSE in 2003 see: http://web.mac.com/mikereddin/PublicGoods/RMTConference_files/RMTTitmussMeinhardt%20Fund%20%26%
20Biographies.htm also on http://www.ntpu.edu.tw/sw/titmuss2.htm last accessed 13.03.2012. And from A. H. Halsey, 'Titmuss, Richard Morris (1907–1973)', rev. *Oxford Dictionary of National Biography*, Oxford University Press, 2004 [http://www.oxforddnb.com/view/article/31763, accessed 13 March 2012] In the 1940s Titmuss publishing a series of founding papers for the subject of social medicine, and together with Jerry Morris established a "Social Medicine Research Unit" funded by the MRC Jane E. Lewis, *What Price Community Medicine*, 1986, p.40n68. Abel Smith was the successor to Titmuss at the LSE and an economist specialized in health systems, and particularly NHS: Peter Townsend, 'Smith, Brian Abel- (1926–1996)', *Oxford Dictionary of National Biography*, Oxford University Press, 2004; online edn, Oct 2006 [http://www.oxforddnb.com/view/
article/60482, accessed 13 March 2012]. Smith had worked on health service financing with Titmuss since the 1950s, and his later works for WHO and governments, amongst them a study on cost sharing in Tanzania were highly influential: E. P. Mach et al., *Planning the Finances of the Health Sector*, 1983; Brian Abel-Smith et al., *Can the Poor Afford Free Health Services*, in Health Policy and Planning, 1992; Brian Abel-Smith et al., *Pvoerty, Development and Health Policy*, 1978; B. Abel-Smith et al., *International Study of Health Expenditure*, 1967. Arthur Williams was a specialist in Tuberculosis research in East Africa who had returned to England in 1961, where he served as the director of postgraduate medical studies at the University of Oxford at the time when the Titmuss report was drafted: M. J. Williams, *Arthur Williams*, in BMJ: British Medical Journal, 2005. Christopher Wood is one of the great names in community health in East Africa. In 1963 he assumed responsibility for setting up a training program at the DSM Medical School. He later became the founding professor of Community Health at the UDSM before he took in 1973 a post at AMREF, an organization to which he became the Director General in 1985. A short bio of Wood is found on the AMREF website. www.amref.org/who-we-are/prof-chris-wood-/ last accessed 11.11.2011.

[58] African Medical and Research Foundation et al., *Health Services of Tanganyika*, 1964, p. 84. This graveyard contained many vestiges of health care provision that were later termed Primary Health Care, cf on Kenya: Miriam S. Chaiken, *Primary Health Care initiatives in colonial Kenya*, in World Development 1998.

Titmuss report was concerned to a substantial degree with the functioning and autonomy of state services, and therefore was largely about Development State building.

The Committee overarched this administrative suggestion by laying out the mission for the Tanganyikan state:

> What lies ahead for Tanganyika is a challenging opportunity to pioneer, develop an set standards of health care which could be an inspiration and an example for other independent nations [...]. Tanganyika will be attempting to do in a relatively short period what more developed societies only achieved after a much longer period of trial and struggle.[59]

It was here that the report raised a voice for a departure from the West. In a situation when the "Third World" constituted itself, the Titmuss plan inserted Tanganyika into the block of the nations in development.[60] The report stated how important planning was and, at the same time, called the Tanganyikan nation to "harness the community development and self-help movement to the work of the local health services." At the same time, the national development direction which, the committee suggested, hinged – for rural areas – on the suggestion for the centralization of rural health care development. It was, however, one of the recommendations which were *not* incorporated into the Five-Year Development Plan for 1964-69 which was based on the Titmuss report.[61]

The report noted explicitly that "it would be unwise and inappropriate, even if it were feasible, to transport to Tanganyika an entirely western pattern of health services".[62] Still, to a large degree, the 'new experts' adopted the late colonial Mandate formulae in a new national programme. In its recommendations, the report revived the health centre approach and specified a programme of "health units" to service the country evenly. The Voluntary Agencies should be "asked to withdraw gradually" from this sector. The report made many recommendations on the hospital sector, too, a sector considered underdeveloped to service the nation, and it advocated the extension of curative services through general hospitals. This was a sector where the contribution of the Voluntary Agencies was explicitly sought.[63] On the matter of medical training the committee also retained the idea that African staff needed to be trained

[59] African Medical and Research Foundation et al., *Health Services of Tanganyika*, 1964, p. 214-220, all following quotes from these pages.
[60] Eric John Hobsbawm, *Zeitalter der Extreme*, 1998, p. 287.
[61] Anthony Kopoka, *Provision of Health Services in Tanzania*, in Electronic Publications from the University of Dar-es-Salaam, 2000, p. 5; Gerardus Maria van Etten, *Rural Health Development in Tanzania*, 1976, p. 41.
[62] As there had been so many (unrealized) ideas, there was little room for the report to be overly inspired in developing innovative ways to tackle the challenges the young nation faced (much more so as it left out the 'traditional' sector entirely). African Medical and Research Foundation et al., *Health Services of Tanganyika*, 1964, p. 80, this chapter 83 of the report also shows the small amount of knowledge available about health needs. Neither did the report specify what the health rights and entitlements of the Tanganyikan citizen were. Anyway, the choice Tanganyika had was rather rhetorical: "They can choose to have smaller, healthier and better fed families. They can choose to have better educated children or uneducated children. They can decide the future of Ujamaa", the reports states on p. 221. For the short discussion of the Titmuss report by Iliffe see: John Iliffe, *East African Doctors*, 1998, p. 201. Compare with Iliffes's discussion of the the 'radical' departure in the late 1960s and early 1970s on pp. 202-203. Bruchhausen describes the medical development plan of 1969 as a the anticipation of the Alma Ata declaration of 1978: Walter Bruchhausen, *Medizin zwischen den Welten*, 2006, p. 132. See: Malcolm Segall, *The Politics of Health in Tanzania*, 1972. Gerardus Maria van Etten, *New strategies of rural health development in Tanzania*, in Trop. geogr. Med., 1971; Oscar Gish, *Planning the Health Sector*, 1975.
[63] African Medical and Research Foundation et al., *Health Services of Tanganyika*, 1964, pp. 223-224, 227 for suggestions on how to handle this with a targeted system of grants in aid pp. 150-224, p. 228.

faster than a full-blown University programme would allow. The idea of training a class of African doctors with a slightly reduced training, appropriate to the needs of the young nation, in the report called *Medical Practitioners*, propelled Tanganyika into the forefront of countries that propagated alternative approaches to medical professionalization and expertise for rural health services. These Tanganyika trained professionals "should be regarded as 'doctors' by the nursing and technical staff, and their training should emphasize the needs of the rural practitioner. At this moment, there were already institutions in place, which trained lower-grade health professionals, the *Medical Aids* who were meant to take over dispensaries in the rural areas from dressers. One of these institutions was in Ifakara.[64]

## The DftZ: Recruiting doctors

At the same time, Tanganyika and Switzerland experienced how difficult it was to bring fully university trained doctors to Tanganyika. Bryceson, the first Minister of Health who had also convened the Titmuss commission, requested assistance from the Swiss Government for the recruitment of medical doctors. Faced with a brain drain of colonial doctors, he came up with the idea of bringing Swiss doctors to Tanganyika.[65] This was the first concrete venture of the DftZ into development cooperation with Tanganyika, but it marked its early days with a failed attempt to assist Tanganyika in its efforts to gear up its medical services. The DftZ engaged many partners in this project to send medical doctors to Tanganyika – but the outcome of the affair

[64] African Medical and Research Foundation et al., *Health Services of Tanganyika*, 1964, pp. 232-233, pp. 188-239. Tanzanias approach was often explained by the Swiss as an African adaptation of the Chinese Barefoot Doctors: ASML ASgelb_VORSTAND_O2 GV 1976-1979/1976: *Appert, O.: Beispiel Ifakara. Kurzreferat im Rahmen der Berichterstattung über die heutigen Aktivitäten des SKMV [anlässlich GV 18.09.1976]*; ASML R1T1AS2 Abgeschlossene Projekte/ MV 81/64 Arzthaus Ifakara: *letter Missionsärztlicher Verein, Luzern 28.01.1982 to Gruppe für Mission und Dritte Welt der Pfarrei St. Elisabeth 8802 Kilchberg*. Tanzanian Medical Assistants were however trained on much higher level than Chinese Barefoot Doctors, who compare better to the 'dressers' P.S. Mganga, *Visit to China*, in Afya, 1968. Peter Wilenski, *The delivery of health services in the People's Republic of China*, 1979. Lesley Doyal et al., *The political economy of health*, 1983 [1979], pp. 288-289. Willy De Geyndt et al., *From barefoot doctor to village doctor in rural China*, in World Bank Technical Paper, 1992. John Iliffe, *East African Doctors*, 1998, p. 47. Also there was a stronger element of 'traditional' medicine in Chinese barefoot doctor medicine. There were at least two training programmes devised, one for AMO's which failed totally by 1968 and another one for Medical Assistants: John Iliffe, *East African Doctors*, 1998, pp. 127-128. Also see: Kris Heggenhougen et al., *Community Health Workers*, 1987. N.R.E. Fendall, *The Medical Assistant in Africa*, in Journal of Tropical Medicine and Hygiene, 1968; Oscar Gish, *Doctor Auxiliaries in Tanzania*, in The Lancet, 1973; T. Kue Young, *Socialist Development and Primary Health Care: The Case of Tanzania*, in Human Organization, 1986, pp. 130-131. Of little help, apart from his pointing out the importance for medical profession of the 'brokerage' position towards international institutions and development aid: John A. Harrington, *Between the State and Civil Society*, in The Journal of Modern African Studies, 1999. For a contemporary view warning against a departure from established levels of training see: F.G. Sembeguya, *Presidental Adress 1962. The Growth of an Indigenous Medical Profession*, in East African Medical Journal, 1964. on the diverging interests regarding academic training and turn out of medical worker inside Makerere see also L. A. Reynolds et al., *British Contributions*, 2001, pp. 31-32. Medical Practitioners, more commonly called Assistant Medical Officers were meant to conform to the WHO report on "Internationally Acceptable Minimum Standards of Medical Education WHO, *Internationally acceptable minimum standards of medical education: report of a study group [meeting held in Geneva from 4 to 8 December 1961]* 1962. The Committee had visited Ifakara African Medical and Research Foundation et al., *Health Services of Tanganyika*, 1964, p. xiv. Mandara remembers that there were strong voices against 'sub-professionals' treating Tanganyikans: M.P. Mandara, *Health services*, 1991, p.5.

[65] BAR E2200.83 (A) 1983/26 B.8.15.1: Der Delegierte für technische Zusammenarbeit, *Letter to CH Generalkonsul DSM. 27.07.1961 "Arbeitsmöglichkeiten für Schweizer Ärzte in Tanganjika"*. BAR E2003-03 (-) 1976/44 t.941.1 Tanganyika: Messmer, *Letter to Swiss Embassy London. Bern 30.08.1961*. The Directors of Services are listed in Helmut Goergen; Walter Bruchhausen; Kirsten Kuelker, *History of Health Care in Tanzania*, 2001, pp. 54-55. There was a practice to assist Swiss who were looking for work abroad, see: Berta Coninx-Girardet, *Britisch-Ostafrika*, 1951.

was frustrating to all sides. The file at the DftZ carries the interesting title "Opportunities for doctors to work in Tanganyika"[66] and reflects a process that must have taught a lesson about the limits of development cooperation to many: it showed that the frontiers of Development were not unbounded pioneering spaces but rose on pre-regulated fields of professional struggle. The cosmopolitan ideals of the medical profession were reined in by boundaries that limited the attractiveness of extra-national work. Notably, the events presented in the next couple of pages show that the medical profession at the time of independence was not organized to provide doctors for developing nations. This was true, in particular, for the Swiss mainstream institutions like the federal government's Development Cooperation Service (DftZ) or the Swiss Association of Medical Doctors (FMH). Compared to them, the missions had continued to recruit doctors for their institutions through their transnational ties (see the section on the SKMV further in the chapter).

Tanganyikan political leaders, Julius Nyerere in particular, were well aware of the challenges their young nations faced with decolonization. They had promised to fight 'ignorance, poverty and disease', but knew it was impossible without support from some of those who had the resources to help. Tanganyika had roughly a dozen of African doctors in service at the moment of independence.[67] Without much programmatic and conceptual preparation, the Swiss DftZ jumped into action. It felt that it was helpful to expose Swiss doctors to medical work in the developing world. DftZ offered to support doctors going to Tanganyika because tours in Tanganyika had presented a case for young doctors to profit from stays in Eastern Africa:

> young Swiss doctors would find an extraordinary richness in sick-material ("Krankenmaterial") particularly in tropical diseases and could take a responsible task [...] that would at the same time be a] welcome relief [ to the hospitals in Tanganyika].[68]

In May 1961, Tanganyika's Minister of Health publicly announced his pleasure in accepting what he understood to be an official proposal by Switzerland to send 18 doctors to Tanganyika. The group was to consist of a mix of experienced and newly qualified doctors, including two women, some of whom had 'tropical experience.[69] Bryceson had clearly made the announcement quite unilaterally, confronting the Swiss, who were still considering the viability of the plan, with a "*fait accompli*".[70] It is unclear how Bryceson had mistaken this proposal as a commitment, but he might have understood the presence of 18 medical doctors loosely

[66] BAR E2003-03 (-) 1976/44 t.941.1 Tanganyika: *file: Arbeitsmöglichkeiten für Schweizer Ärzte*.
[67] John Iliffe, *East African Doctors*, 1998, p. 127. eighty per cent of registered doctors at the time were "Asian" (ditto, p. 121). African Medical and Research Foundation et al., *Health Services of Tanganyika*, 1964, p. 14.
[68] BAR E2003-03(0) 1976/44 o.941.1 Ausbildung afrikanischer Krankenpfleger am Kantonsspital in Zürich: DftZ, *Letter to Kantonsspital Zürich. Bern 06.03.1961*.
[69] BAR E2003-03 (-) 1976/44 t.941.1 Tanganyika: Tanganyika Information Services, *Press release, 13.05.1961: Switzerland to send 18 doctors to Tanganyika*; BAR E2003-03 (-) 1976/44 t.941.1 Tanganyika: Tanganyika Permanent Secretary to the Treasury, *Letter do DftZ, Messmer. DSM 26.05.1961*.
[70] BAR E2200.83 (A) 1983/26 B.8.15.1: Der Delegierte für technische Zusammenarbeit, *Letter to CH Generalkonsul DSM. 27.07.1961 "Arbeitsmöglichkeiten für Schweizer Ärzte in Tanganjika"*; BAR E2003-03 (-) 1976/44 t.941.1 Tanganyika: Messmer, *Letter to Swiss Embassy London. Bern 30.08.1961*.

interested in working in Tanzania at an information meeting as a group of doctors being definitely prepared for their departure.[71]

At the time of the meeting with the aspiring doctors, it was already clear that Switzerland was hardly able to produce 18 doctors for the programme. From the background of a 'shortage' of doctors in Switzerland, and confronted with the intricacies of clarifying the terms of practice for Swiss doctors in Tanzania, it was soon obvious to the Swiss that they were in trouble. The information event for doctors was organized by the DftZ and the Swiss Doctors' Association, the FMH and brought some of the top actors together: Tanganyika's Chief Medical Officer, the DftZ and the Swiss Government Agency for Labour (BIGA) as well as the FMH. The 'Ifakarians', Prof. Rudolf Geigy and the Capuchin Walbert Bühlmann presented first-hand information on Tanganyika. The candidates for the Tanganyika deployment were promised more detailed information on their wages after the meeting.[72] But to the Swiss it was clear at this point that not more than half a dozen doctors could be recruited at best, and the whole matter came to a standstill.[73] The places planned for the Swiss were said to be taken by doctors from other nations.[74] Meanwhile, the changes in Tanganyika leading up to full independence meant that it was not clear who were to be the people to talk to.[75]

In February 1962, the Swiss conglomerate of DftZ and FMH decided to re-approach the Tanganyikans and asked the Capuchin Father Gämperle, who was in charge of the Msimbazi centre at the outskirts of Dar es Salaam, to find out if there was still an interest in the project in Tanganyika. Gämperle found that there was.[76] It was agreed that the Tanzanian Government should make a formal application to the DftZ for support with doctors recruited in Switzerland.[77] The problems that arose now were mainly financial and bureaucratic. The DftZ and the Tanganyikans were ready to solve the problems, but it took a long time while the doctors wanted to proceed with their careers. The DftZ was prepared to top up the doctors' salaries, but even then Tanganyika could only afford to hire a fraction of the doctors – a matter that was even

[71] BAR E2200.83 (A) 1983/26 B.8.15.1: Der Delegierte für technische Zusammenarbeit, *Notiz über das Ergebnis der Besprechung vom 23.05.1962 mit Dr. C.V. Mtawali, Deputy Permanent Secretary of the Ministry of Health and Labour in Tanganyika im Zusammenhang mit der Entsendung von Schweizer Ärzten nach Tanganyika*.

[72] BAR E2200.83 (A) 1983/26 B.8.15.1: *Notiz zuhanden von Herrn Dr. Keller und Herrn Messmer [Bern 12.07.1961]*. BAR E2200.83 (A) 1983/26 B.8.15.1: Generalsekretariat des Schweiz. Ärzteorganisation, *Arbeitsmöglichkeiten in Tanganjika. Zusammenfassung der Ergebnisse der informatorischen Besprechung von Donnerstag, 29.06.1961, 14.00 in Bern*.

[73] BAR E2200.83 (A) 1983/26 B.8.15.1: *Letter to Generalsekretariat des Schweiz. Ärzteorganisation re: Arbeitsmöglichkeiten in Tanganjika. Bern, 12.07.1961* In November there were only 4 possible candidates left.

[74] BAR E2200.83 (A) 1983/26 B.8.15.1: Der schweizerische Generalkonsul in Tanzania, *Letter to DftZ ("Herr Abteilungschef"). 07.11.1961*.

[75] BAR E2003-03 (-) 1976/44 t.941.1 Tanganyika: DftZ, *Letter to Swiss Consulate DSM. Bern 15.02.1962*.

[76] BAR E2200.83 (A) 1983/26 B.8.15.1: Der Delegierte für technische Zusammenarbeit, *Letter to CH Generalkonsul DSM. 15.02.1962: "Entsendung von Schweizer Ärzte nach Tanganjika"*. BAR E2003-03 (-) 1976/44 t.941.1 Tanganyika: Lukas Gämperle, *Letter Tanzanian Episcopal Conference to Dftz. DSM 01.03.1962*.

[77] BAR E2200.83 (A) 1983/26 B.8.15.1: Der Delegierte für technische Zusammenarbeit, *Notiz über das Ergebnis der Besprechung vom 23.05.1962 mit Dr. C.V. Mtawali, Deputy Permanent Secretary of the Ministry of Health and Labour in Tanganyika im Zusammenhang mit der Entsendung von Schweizer Ärzten nach Tanganyika*. BAR E2200.83 (A) 1983/26 B.8.15.1: F.J. Kalambo, *Letter for the Permanent Secratary of the Treasury to W.Diener, Consul of Switzerland. DSM 07.09.1962*. BAR E2200.83 (A) 1983/26 B.8.15.1: Der Delegierte für technische Zusammenarbeit, *Letter to Dr. B. Beretta. 12.10.1962*.

mentioned at the WHO 15th General Assembly.[78] Swiss doctors found it difficult to imagine a career in Tanganyika. The letters with queries and answers about the personal finances and life standards of doctors in Tanganyika fill the file at the Swiss Federal Archive.[79] A doctor could neither live "comfortably" from his wage in Tanganyika nor could (s)he save money for their lives after their return.[80] Another issue was that all of the original four or five Swiss applicants lacked the documentation necessary for their registration in Tanganyika.[81] A major obstacle in the way of registration was the lack of experience of the Swiss doctors, because it was quite possible that the Swiss doctors would find themselves in a post with no other doctor and often without European staff at all.[82]

In October 1962 there was only one Swiss doctor left as a candidate (but he, too, was at the time already working in Yemen). The Swiss Consulate in Dar es Salaam still expected that the FMH could find three more doctors. But the whole thing seems to have completely evaporated afterwards. The "unpleasant" affair, as it was called by the Swiss General Consul Mossaz in internal papers in April 1962, had become a total failure by the end of that year. The matter of the doctors offered another opportunity for the public appearance of a Tanganyikan Minister of Health in Switzerland, but the event held at the University of Basel could not change the fate of the affair. "The needs are great and we cannot wait", Bryceson reminded the audience but his message could not produce further action.[83] The failure showed the incapability of the DftZ in league with the FMH to recruit doctors to work in Tanganyika in the public sector there as regular doctors. It was disheartening for the Swiss Development Agency to realize that it could not provide the experts needed for medical development work.[84] The matter also came to an end because of general DftZ policy: in late 1963, a new rule was set.[85] Switzerland explained to the Tanganyikan Government that:

> as a matter of principle, [...] all medical aid (dispatch of doctors, nursing personnel, medicines and medical equipment) would no longer be considered as 'Technical Help' but as

[78] BAR E2200.83 (B) 1983/26 C9.1: Tanganyika Information Services, *Ten times more doctors needed to provide reasonable health service [press release, 14.06.1982]*. The statement by Kamaliza is recorded in the Official Record of the 15th WHA, part II on p. 85- 87. Kamaliza demanded the WHO to procure "an army of well-trained health workers…". He also mentioned the work in Ifakara of the Basel Foundation and R. Geigy by name. The record is available online: apps.who.int/iris/bitstream/10665/85749/1/Official_record119_eng.pdf.
[79] BAR E2003-03 (-) 1976/44 t.941.1 Tanganyika: *file: Arbeitsmöglichkeiten für Schweizer Ärzte*.
[80] BAR E2200.83 (A) 1983/26 B.8.15.1: Der schweizerische Generalkonsul in Tanzania, *Letter to DftZ. 27.09.1962*.
[81] BAR E2200.83 (A) 1983/26 B.8.15.1: Medical Council of Tanganyika et al., *Letter to Schweiz. Ärtzeorganisation [FMH]. DSM 22.02.1962*.
[82] BAR E2200.83 (A) 1983/26 B.8.15.1: Der Delegierte für technische Zusammenarbeit, *Letter to CH Generalkonsul DSM. 01.05.1962: "Arbeitsmöglichkeiten für Schweizer Ärzte in Tanganjika"*. BAR E2003-03 (-) 1976/44 t.941.1 Tanganyika: DftZ, *Letter to Swiss Consulate DSM. Bern 01.05.1962*. BAR E2200.83 (A) 1983/26 B.8.15.1: Der schweizerische Generalkonsul in Tanzania, *Letter to DftZ. 19.04.1962*.
[83] hj, *Tansania plant seine Zukunft*, Basler Nachrichten, 197, 12.05.1963.
[84] By 1967 it was the Tanzanian ministry of Finance who asked Switzerland to provide doctors. SDC had to turn down, now with the explanation that Switzerland lacked doctors herself. Eventually Chinese doctors filled the gap: BAR E2200.83(B) 1983/27 771.22.6: *file overview: Projekte der Regierung von Tanzania*, document dated: 26.01.1968. BAR E2200.83(B) 1983/27 771.22.6: *file overview: Projekte der Regierung von Tanzania*, documents dated 05.05.1967 and 1905.1906.1967.
[85] PAL Sch 1060.3: P. Hilmar Pfenniger, *Letter, Sursee? to Dr. Karl Schöpf, 18.12.1963*. BAR E2003-03 (-) 1976/44 t.941.1 Tanganyika: DftZ, *Letter to Swiss Consulate DSM. Bern 20.01.1964*.

> 'Humanitarian Work' and would for that reason now fall within the competence of the Section of International Organizations in the Federal Political Department.[86]

This meant that health system building was no longer part of the national Swiss development agenda.[87] In 1966 a project in the health sector was explicitly ruled out.[88] The exclusion of health services from DftZ practice was never total, however.[89] Most notably, it opened the field for private actors to engage in the development of health care systems, and to search assistance from DftZ for their activities. Rather than spreading a Swiss presence across the new nation, this would result in a concentration on projects with specific ties to Switzerland, and – not least – it came to mean that Ifakara was to be turned into a hotspot of Swiss medical development cooperation.[90]

An important step for the continuation of medical development cooperation on the basis of private initiatives was a bilateral agreement with Tanzania on development cooperation signed in 1966.[91] This agreement assisted private investment in development cooperation, including the work of the Swiss Capuchin Mission in the St. Francis Hospital in Ifakara.[92] In the wake of this agreement, it would seem that private actors were able to leverage a growing amount of development aid money and that even DftZ money spent towards Tanzania rose following this agreement, although the Swiss Government service ran almost no projects on their own any more. But with private organizations promoting development activities in Tanzania, the East African country quickly rose to eighth place among recipient countries in Africa in 1966, then to fifth in 1968 and third place in 1970.[93]

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[86] BAR E2200.83 (A) 1983/26 B.8.15.1: Der Schweizerische Generalkonsul in Tanzania, *Letter to Permanent Sec [Tanganyika]. 17.11.1964*. Also: BAR E2200.83 (A) 1983/26 B.8.15.1: Der Schweizerische Generalkonsul in Tanzania, *Letter to Permanent Sec [Tanganyika]. 17.11.1964*; BAR E2003-03 (-) 1976/44 t.941.1 Tanganyika: DftZ, *Letter to Swiss Consulate DSM. Bern 20.01.1964*.

[87] Switzerland seems to have turned down a demand by the Tanzania Government to assist with technical equipment to government Hospitals BAR E2005(A) 1978/137 t.311. Tanzania Projekte und Aktionen: *File overview: Tanzania Projekte und Aktionen*. BAR E2200.83 (A) 1983/26 B.8.: Der Schweizerische Generalkonsul in Tanzania, *Letter to EPD, DftZ, Bern. 25.10.1965*.

[88] BAR E2005(A) 1978/137 t.311. Tanzania Projekte und Aktionen: DftZ et al., *Überlegungen zur Abklärungsmission in Tanzania. 31.05.1965*.

[89] It was not strictly adhered to: In Ruvuma DftZ supported agricultural 'vulgarisation', by sending agricultural experts to assist the Rural Development Association, but the programme also included two nurses. BAR E2200.83 (B) 1983/27 771.22.7 Vol.I & II; and 771.22.7.A Vol.II. & III: *[entire file] Ruvuma Development Association Songea*; BAR E2005(A) 1980/82 t.311 Tansania: Schweizer Botschaft in DSM, *Letter Swiss Ambassador to DftZ. DSM 27.09.1969*; BAR E2200.83(B) 1990/26 t.771.20: Rudolf Dannecker, *Rapport über die Mission nach Tansania - Kenia vom 08.03.1970 - 29.03.1970*. On the history of the RDA see also Michael Jennings, *Surrogates of the State*, 2008. Leander Schneider, *Developmentalism*, 2003.

[90] The DftZ supported training institutions like the Rural Aid Centre (RAC) in Ifakara, University institutes like the Pathology section in what became the national medical school at Muhimbili Lukas Meier, *Swiss Science*, 2014, pp. 150-154. In the early 1970s it even supported the St. Francis Hospital so that it could rebuild its operation theatre section (see chapter 10) and also by staff grants paid via the lay confessional recruiting agencies.

[91] BAR E2200.83 (A) 1983/26 B.8.: Der Schweizerische Generalkonsul in Tanzania, *Letter to EPD, DftZ. 24.08.1963*. BAR E2200.83 (B) 1983/27 771.20: *file: Technische Zusammenarbeit Schweiz -Tanzania: Accord cadre*. BAR E2200.83 (A) 1983/26 B.8.: Der Schweizerische Generalkonsul in Tanzania, *Letter to EPD DftZ. 19.07.1965*.

[92] BAR E2200.83 (A) 1983/26 B.8.: *Technische Zusammenarbeit Schweiz-Empfangsstaat 771.20 Accord cadre*.

[93] Numbers in this chapter are distilled from tables in: BAR E2807(-) 1974/12/66 available dodis.ch/31756: Kommissionen für technische Zusammenarbeit, *Programme de coopération technique 1965-67. Résumé géneral*; Schweizerische Eidgenossenschaft, *Botschaft des Bundesrates an die Bundesversammlung über die Weiterführung der technischen Zusammenarbeit der Schweiz mit den Entwicklungsländern (vom 10.11.1971)*, (Bern1971).

## The Swiss Catholic Association for Mission Medicine: Mission and Development Agency

The Catholic Swiss Association for Mission Medicine (SKMV) was a major supporter of Catholic mission medicine. For a long time this organization of mostly laypersons in church, but professionals in health had supported the Swiss Capuchin mission's medical work. In the first 25 years of its existence since the mid-1920s, the SKMV had been an important support base for mission medical work, and it had donated a total of about CHF 160,000 towards medical work by Swiss missionaries and mission societies.[94] In the early 1950s, the association had felt that donors had lost their enthusiasm ["Gebemüdigkeit"] at a time when a "mission spring in Africa" needed the financial input of the mission societies.[95] According to the SKMV's perception this mission spring "aerated the mission-friendly soil" in Switzerland and large sums of money came directly to the SKMV.[96]

In the post-War period, the Association gradually changed the form of support it gave to mission medicine. From its 25th anniversary in 1951, the SKMV reduced the weight it accorded to public propaganda in Switzerland and increasingly invested its energy and funds in projects.[97] At the same time, the association reported how Bishop Maranta had mentioned that Ifakara needed a hospital urgently.[98] The association which had already played a fundamental role in the first Capuchin attempt at establishing a Mission hospital in Mahenge (see chapter 6 above), once again donated the largest part of its contributions to the Capuchins in Ulanga: Dr. Schöpf received money for the building and continuing extension of the hospital, and Sister Arnolda for her work in the maternity unit. Most of the other sisters also received regular or exceptional contributions for their medical enterprises.[99] Only by 1962 were the contributions spread more evenly across the Swiss Catholic Missions.[100] Yet, by that time, as we have seen, Ifakara had

[94] SKMV, *Jahresbericht 1961 des SKMV*, in Missionsärztliche Caritas, 1961. In 1953 the "Schweizerische katholische Verein für missionsärztliche Fürsorge" changed its name into "Schweizerischer Katholischer Missionsärztlicher Verein". NB,I have opted to use the SKMV throughout this thesis for readability. For the history of the association see: P. Odorich Koch, *Missions-Ärztliche Fürsorge*, in Missionsbote der Schweizer Kapuziner in Afrika, 1927. hr, *Missionsärztlicher Verein 1926/1937*, in Missionsärztliche Caritas, 1938. ASML R3T3O11/SM-Geschichte ab 1926: *notiz zum file*. Friedrich Kürner, *25 Jahre schweizerischer missionsärztlicher Verein*, in Missionsärztliche Caritas, 1951. Friedrich Kürner, *Missionsärztliche Fürsorge (40 Jahre Schweizerischer missionsärztlicher Verein)*, in Missionsärztliche Caritas, 1966. In 1987 the SKMV became Solidarmed, today a major Swiss NGO when it comes to health services development cooperation in Africa: Walbert Bühlmann, *GV von Solidarmed (ehemals SKMV) vom 19.09.1987*, in Bulletin Medicus Mundi Schweiz, 1988. Edwin Berchtold, *GV des SKMV vom 20.09.1986*, in Bulletin Medicus Mundi Schweiz, 1987.

[95] Friedrich Kürner, *Jahresbericht 1951/52*, in Missionsärztliche Caritas, 1952; Friedrich Kürner et al., *Jahresbericht 1954*, in Missionsärztliche Caritas, 1954.

[96] SKMV, *Jahresbericht 1961 des SKMV*, in Missionsärztliche Caritas, 1961.

[97] The baseline of project contributions was the annual donations to each of the medically trained missionaries for use in their institutions. See the annual reports of the SKMV in the *Missionsärztliche Caritas*. Increasingly the SKMV extended this system and made allowances to nursing sisters too. E.g. towards Sr. Consolata's maternity work: SKMV, *Jahresbericht 1963 des SKMV*, in Missionsärztliche Caritas, 1963.

[98] SKMV, *Jahresbericht 1953 des SKMV*, in Missionsärztliche Caritas, 1953.

[99] SKMV, *Jahresbericht 1958 des SKMV*, in Missionsärztliche Caritas, 1958. In 1959 the other stations of the Capuchins received the second and third largest contribution from the SKMV of all hospitals in Africa and Asia, notably behind Ifakara, who received the largest.SKMV, *Jahresbericht 1959 des SKMV*, in Missionsärztliche Caritas, 1959.

[100] SKMV, *Jahresbericht 1962 des SKMV*, in Missionsärztliche Caritas, 1962. and reports on following years.

received another large contribution towards the TB hospital through another channel, the Missionsjahr.

With the growing need for staff (and the curtailing of the time health workers from Europe spent in missionary medical work overseas), the role of SKMV as a recruiting agency became ever more important. In the mid-1960s, a new generation took over at the helm of the council of the SKMV: the SKMV now was increasingly grounded on knowledge brought back from experience in Africa, because it could draw on the flow of doctors returning from the field. The SKMV had always been an important place where the Swiss could learn about health, medicine and health care in the tropics. Now, doctors started to circulate back and forth through the SKMV, and the organization would strengthen its importance as a point of access to an international network of knowledge and expertise. Hans Studer came in as a new President in the mid-1960s and was seconded by a Vice-President, Edgar Widmer, who was not only a nephew and godson of Bishop Edgar Maranta, but who had also written a medical history dissertation on the Capuchin mission's medical work in Tanganyika and worked in Ifakara for two and a half years as a medical doctor.[101] They presided over an organization, which had just added another 500 new members, and now totaled more than 2,000 members on its roll.[102]

With these new people, the SKMV became – in addition to the regular financial contributions to the medical work of missions – a dedicated recruiting agency, and it started to professionalize the procurement of drugs for the missions.[103] In the course of time, the SKMV would recruit for Tanzania more than the 18 doctors who had been 'promised' by the DftZ.[104] Also, the SKMV worked on the issue of the professional self-conception of the doctors, explaining that the pioneering period of Catholic mission medicine was by necessity followed by sound administration and scientific management of Catholic medical institutions.[105] As Mission and Church hospitals in the South grew and attracted more staff, networks grew tighter amongst doctors with an interest in development and medicine, and amongst the new bodies supporting

[101] Edgar Widmer would be a most valuable person for Ifakara as he lent his weight to the support of the medical institutions in Ifakara, but also connected beyond that and tried to strike a balance between the historical foundations on which Ifakara built and a pushing new frontiers of primary and community medicine within both medical and Catholic circles. He has himself created a collection of his speeches and articles, which represent this well: Edgar Widmer, *Fürsprech für "Gesundheit für Alle". Advocating Health and Care 1963-2007*, (2007). On his role as a liaisons person for Ifakara see: PA Schellenberg Folder Nutrition Promotion Muttermilch Hans Studer, *Letter to P.Schellenberg. Luzern 02.08.1972*. From that time a new flow of people came back from Ifakara and joined the SKMV or Medicus Mundi and similar organizations. Amongst the early ones: Per Schellenberg and Rüdiger Finger. Early papers of Schellenberg include: PA Schellenberg Folder Nutrition Promotion Muttermilch Per Schellenberg, *Entwicklungshilfe aus medizinischer Sicht. Erfahrungen aus Tansania [Manuscript for paper read at Spital Limmattal, 09.05.1974]* Documenting Finger's engagement for preventive medicine and "Primary Surgery": DAK folder 'hospital ifakara' in Acc. Secretary na Serikali Shelf I & III: Rüdiger Finger, *Letter to P. Iteka. Ifakara 00.03.1972*; Rüdiger Finger, *Primary Surgery*, 2011.

[102] Friedrich Kürner, *Jahresbericht 1965/66*, in Missionsärztliche Caritas, 1966.

[103] Hans Studer, *Ausblick*, in Missionsärztliche Caritas, 1966. *Interviews with Edgar Widmer, Thalwil, 23.10.2008 und 27.10.2008*.

[104] Many of these doctors have written final reports held in two folders in ASML, and partly also in PAL or even in BAR holdings.

[105] SKMV, *Jahresbericht 1967 des SKMV*, in Missionsärztliche Caritas, 1967, p. 2.

these institutions.[106] The Vice-President of SKMV, Edgar Widmer, soon acted as a central figure in the international network of Medicus Mundi, in which a range of organizations with an interest in the establishment of health systems in developing countries came together. Together with the SKMV, Medicus Mundi provided an important transnational link for hospitals and doctors across the continents, and strengthened the St. Francis hospital network.[107]

## The Rural Aid Centre: Training rural health workers

While the DftZ struggled to recruit even a single doctor from Switzerland, the private initiatives in Ifakara thrived. The Capuchins extended the St. Francis Hospital with a 120/130 bed TB section. The chemical industry of Basel in league with the Swiss Tropical Institute established the "Rural Aid Centre", later the "Medical Assistants Training Centre" in Ifakara.[108]

The Rural Aid Centre (RAC) aimed at training Africans (who were destined to work in rural Africa) in scientific knowledge. As it turned out, the St. Francis Hospital was to be the clinical base for the school while its general scientific base came from the Swiss Tropical Institute's Field Laboratory (STIFL) that had been established in a section of the St. Francis Hospital (see chapter 8). The aims of the STIFL had been to collect specimens for research in the laboratories of the Swiss Tropical Institute in Basel, to train young Swiss scientists in the field, and to contribute to the development of Africans by peer cooperation and by "demonstrating precise work and well-defined planning in an exemplary manner".[109] The latter aspect quite naturally led to the project for a training institution such as the RAC. This institution subscribed to local curricula, and aimed at turning out so-called Rural Aids – health workers for rural services. The school was to be established and run with the support of the Basel chemical and pharmaceutical industry, who would thus find a way of engaging in development cooperation.[110] Rudolf Geigy, director of the Swiss Tropical Institute, initiator of the STIFL and himself a member of one of the most influential industrial families in Basel, was the first and major

[106] Klaus Fleischer, *Kirchliche Gesundheitsarbeit*, 2011. Misereor was an important partner to Catholic health institutions, also to St. Francis Hospital: PAL Sch 1061.6: Karl Schöpf, *Letter to E. Maranta. Zams 20.04.1963*. Annett Heinl et al., *Spendenfinanzierte private Entwicklungshilfe in der Bundesrepublik Deutschland*, 2009.

[107] These networks of private actors were important players in pushing medicine in development, and PHC: Socrates Litsios, *Christian Medical Commission*, in American Journal of Public Health, 2004. They also attracted Governments to their discussions and meetings: Ali Hassan Mwiniy, *[Presentation on "the fundamental role of auxiliary personnel in delivering primary health care to the people"]* (paper presented at the General Assembly, Rüschlikon, 1975); BAR E2005(A) 1985/101 t.751-339 Medicus Mundi bd 2: WM, *[Notiz in file to ZN]*. On the history of Medicus Mundi Internationalis see: PA Widmer Edgar Widmer, *Unterwegs für Entwicklung. Erinnerungen anhand von Fotografien*. Also: Edgar Widmer, *Förderung der Basisgesundheitsdienste. Aktivitäten von Medicus Mundi Schweiz* (paper presented at the Geschichte der Tropenmedizin und die Schweiz, Basel, 1992). Together with Lukas Meier, we were given access to the archives of Medicus Mundi Schweiz in Basel, for the annual reports see: AMMS MMS Protokolle Mitgliederversammlung: *Protokolle der GV des MMS*.

[108] Lukas Meier, *Swiss Science*, 2014, pp. 137-143, 184-191; Jürg Bürgi et al., *Mehr geben, weniger nehmen*, 2004, pp. 154, 218.

[109] Thierry A. Freyvogel, *Das Feldlaboratorium des Schweizer Tropeninstituts*, in Missionsbote der Schweizer Kapuziner in Afrika, 1957.

[110] BAR E2200.83 (A) 1983/26 C 9.1.: *Bericht über die Reise der Herren Dr. Arthur Wilhelm, CIBA, und Prof. Rudolf Geigy, Schweizerisches Tropeninstitut, zum Studium der in Ostafrika bestehenden Möglichkeiten für Schweizerische Entwicklungshilfe - Zu handen des Basler Initiativ-Komitees*. Lukas Meier, *Swiss Science*, 2014, pp. 136-137. Jürg Bürgi et al., *Mehr geben, weniger nehmen*, 2004, pp 154-157.

promoter of the RAC.[111] Presenting Tanganyika as the ideal place to start a development project geared on training, he attempted to establish an alliance of the Basel chemical industry (organized in a foundation for Development called BSFEL) with Swiss Government Development Cooperation and the Tanganyikan Government that is with Nyerere himself.[112] The Rural Aid centre was initially meant to evolve into a broader centre for agricultural development.[113] Only the medical side of the centre thrived, however. In 1964, it was firmly entrenched in the Tanzanian training schemes not only for Rural Aids; experienced medical assistants from rural areas of Tanganyika now came to the centre for their training.[114]

Early in the planning stage, the DftZ was approached for support. The good connections with the local population through the Mission were a great foundation for the project, the application held, but if this was to be a truly secular project there was a need to build and equip buildings for teaching and accommodation independently of the Capuchin mission at a projected total cost of about CHF180, 000.[115] This was not a rejection of the Mission – which gave the land needed for the project and also detached its medical staff as teachers and even directors at some point – nevertheless, it was meant to connect the Centre directly to bilateral development cooperation with a business development branch.[116] For the Basel industry, the fact that good connections already existed was a strong point in favor of the project in Tanganyika.[117] But the industry was also interested in going further: the minutes of the BSFEL meetings in 1960s

[111] BAR E2200.83 (A) 1983/26 C 9.1.: *Bericht über die Reise der Herren Dr. Arthur Wilhelm, CIBA, und Prof. Rudolf Geigy, Schweizerisches Tropeninstitut, zum Studium der in Ostafrika bestehenden Möglichkeiten für Schweizerische Entwicklungshilfe - Zu handen des Basler Initiativ-Komitees*. It was particularly through the networks established by Rudolf Geigy, who was well connected with the political and economic elite in Switzerland and well versed in popular side of science that Ifakara was brought into the public light. The son of a powerful industrial family in Basel, Geigy was not only the founder of the STI but also a director of the Council of the prestigious Zoological Gardens in Basel for 25 years. Geigy was well connected into the highest offices of the Swiss State, Swiss Development Cooperation, and Swiss Academic Bodies.
[112] BAR E2003-03(0) 1976/44 t.912.1: CIBA, *Letter to DftZ, re: "Hilfe an unterentwickelte Länder". Basel 14.07.1960*. BAR E2003-03(0) 1976/44 t. t.912.32: DftZ, *Notes, to the file 29.01.1962, and n.d. (Messmer to Geigy)*. Lukas Meier, *Swiss Science*, 2014, p. 139. BAR E2200.83 (A) 1983/26 C 9.1.: *Bericht über die Reise der Herren Dr. Arthur Wilhelm, CIBA, und Prof. Rudolf Geigy, Schweizerisches Tropeninstitut, zum Studium der in Ostafrika bestehenden Möglichkeiten für Schweizerische Entwicklungshilfe - Zu handen des Basler Initiativ-Komitees*.
[113] It seems that the BSFEL, DftZ, and the Swiss Federal Council, had been, it seems, more interested in this part of the project than in the medical side of it: BAR E2003-03(0) 1976/44 t. t.912.32: A Wilhelm, *Letter to DftZ, Hans Keller, Basel 29.08.1961*. BAR E2003-03(0) 1976/44 t. t.912.32: DftZ, *Notes, to the file 29.01.1962, and n.d. (Messmer to Geigy)*.
[114] Describing these students as experienced and open-minded:: BAR E2003-03(0) 1976/44 t. t.912.32: Rudolf Geigy, *Letter to DftZ, Hans Keller. Ifakara, 08.10. 1962*. The perspective of the BSFEL and its propagators was often crudely paternalistic: the RAC was seen as a "difficult experiment in parenting with young Africans" ("schwieriges Erziehungsexperiment"): ASTIBS 6/1/2: Ifakara I/BSFEL: BSFEL, *Die Basler Stiftung zur Förderung von Entwicklungsländern [image brochure text for Expo 1963]*.
[115] BAR E2003-03(0) 1976/44 t.912.1: CIBA, *Letter to DftZ, re: "Hilfe an unterentwickelte Länder". Basel 14.07.1960*.
[116] The Swiss Mission helped with land, so that it could be started at all.: Lm p. 131 PADSM Box 153: *Chronica V [Capuchin Mission Ifakara]*, entry for 10.10.1960. ASTIBS 6/1/2: Ifakara I/BSFEL: BSFEL, *Protokoll "Tanganyika / Entwicklungshilfe der Basler Chemie", 25.05.1961*. About teaching of hospital staff in the RAC: *Interviews with Edgar Widmer, Thalwil, 23.10.2008 und 27.10.2008*. BAR E2200.83(A) 1983/26 B.8.15: *List of teachers of Swiss nationality at the Rural Aid Centre, Ifakara*. Teaching the MATC was done by St. Francis Hospital staff, but probably on a RAC payroll: BAR E2005(A) 1983/18 t.311 Tanzania 5 Rural Medical Aid Centre Ifakara: Oskar Appert, *Projekt Medical Assistant School Ifakara /Tanzania [Ifakara, 12.07.1972]*. The Capuchins later also gave money for the Medical Assistants Training School: PAL Sch 1061.3 Ärzte etc. Verschiedenes / Dr. Appert: Oskar Appert, *Letter to P. Provinzial. Ifakara 15.04.1973*. The differentiation between Mission and secular people at Ifakara did not immediately stick with the Tanganyikan side, who believed that the mission was building the RAC, but bringing in Swiss interests and Swiss university staff. *Eastern Province Annual Report 1960*. TNA: reading room copy.
[117] ASTIBS 6/1/2: Ifakara I/BSFEL: BSFEL, *Protokoll "Tanganyika / Entwicklungshilfe der Basler Chemie", 24.03.1960*. Thierry A. Freyvogel, *The Work at the Rural Aid Centre (R.A.C.) Ifakara, Tanganyika*, in Acta Tropica, 1964.

clearly state the reasons why Tanganyika was chosen for a project. The BSFEL believed in the fast economic growth of the East African economies. "These are projects which have not only a charity character, but through which we also wish to raise goodwill [sic!] for the services and products of our industry."[118] For Switzerland an engagement by a conglomerate of Basel chemical industry firms in Ifakara offered the prospect of starting a new line of 'neutrality and solidarity':

> "What a beautiful task lies ahead for Switzerland, unburdened by a colonial past. The countries prospects for development are limited and therefore our activities should concentrate on projects that constitute achievements small in scale but great in quality."[119]

The business side, i.e. the BSFEL, slowly withdrew its engagement in the RAC in the course of the 1960s and early 1970.[120] By then, the RAC was being refashioned into a fully-fledged Training Centre for Medical Assistants. It established a continuous three-year teaching curriculum instead of short-term courses as a sort of 'field' stage. It also connected much more directly with the priorities of national health care policies in Tanzania.[121] These changes were firmly institutionalized by a planned transfer of the institution into the hands of the Tanzanian state. At the same time, the St. Francis Hospital was of great importance to the MATC because the training was only possible with a larger hospital as a clinical base and the ideas to start this new school came from the context of the hospital. In the beginning, the Hospital director even acted as the head of the MATC, and the Diocese was represented in the Board of the Training Centre.[122]

## Ifakara: the Health Development brand

Based on these investments and networks, Ifakara soon became a buzzword in the parlance of Development in Switzerland, and thus entered the vocabulary of a much broader public than the Catholic mission community in Switzerland. While Switzerland invested

[118] ASTIBS 6/1/2: Ifakara I/BSFEL: BSFEL, *Protokoll "Tanganyika / Entwicklungshilfe der Basler Chemie", 24.03.1960*. ASTIBS 6/1/2: Ifakara I/BSFEL: BSFEL, *Protokoll "Tanganyika / Entwicklungshilfe der Basler Chemie", 03.10.1960*. BSFEL received very positive feedback to its plans from Nyerere in person: ASTIBS 6/1/2: Ifakara I/BSFEL: BSFEL, *Protokoll "Tanganyika / Entwicklungshilfe der Basler Chemie", 03.10.1960*. On the other hand the BSFEL feared nationalization from the very beginning. ASTIBS 6/1/2: Ifakara I/BSFEL: BSFEL, *Protokoll "Tanganyika / Entwicklungshilfe der Basler Chemie", 25.05.1961*.

[119] BAR E2200.83 (A) 1983/26 B.8.: Rudolf Geigy, *Letter to Dr. R. Schenkel, Royal Colleage Nairobi. Ifakara 23.09.1963*. Switzerland was proudly presented as having no colonial in a broad range of publications and reports: STI 6/1/2: Basler Stiftung zur Förderung von Entwicklungsländern, *Protokoll "Tanganyika / Entwicklungshilfe der Basler Chemie", Basel 03.10.1960*. Walbert Bühlmann, *Die Schweiz hilft den Entwicklungsländern: Der Beitrag der kath. Missionen*, in katholisches Missionsjahrbuch der Schweiz, 1960. P. Hilmar Pfenniger, *Editorial*, in Missionsbote der Schweizer Kapuziner in Afrika, 1960.

[120] ASTIBS 6/1/2: Ifakara I/BSFEL: BSFEL, *BSFEL, Protokoll, 24.11.1964*. For this paragraph see: Lukas Meier, *Swiss Science*, 2014, pp. 186-191.

[121] Lukas Meier, *Swiss Science*, 2014, pp. 185-191.

[122] ASTIBS 6/1/2: Ifakara I/BSFEL: BSFEL, *BSFEL, Protokolle der Sitzungen des Stiftungsrates, 1960-1978*, document dated 02.05.1973. The idea to transform the Centre into a training centre with its own multi-year training course for a sort of health professional came was discussed and set into motion in the hospital board: St.Francis Hospital Ifakara et al., *Minutes of the fifth meeting of the 'Board of Governors' SFH, Ifakara [01.09.1970/02.09.1970]*, (PADSM Box 155 Ifakara SFH 2/PADSM Box 155 SFH 61970). It was hoped that Government would come in to pay for the total running cost: St.Francis Hospital Ifakara et al., *Minutes of the sixth meeting of the 'Board of Governors' SFH, Ifakara [18.09.1971]*, (PADSM Box 155 SFH 61971). Eventually these ideas probably led the Hospital on a path that increased the interest of Government to designate the hospital as a district hospital in the context of the division of Mahenge District into Ulanga and Kilombero Districts. See: ASTIBS 6/1/2: Ifakara I/BSFEL: BSFEL, *Aktennotiz der Besprechung, 4.9.1974, im Verwaltungsgebäude Ciba-Geigy AG*.

ideologically into rural development among small mountain communities, as Lukas Zürcher shows for Rwanda or Sara Elmer for Nepal, this discourse was not applicable to Ifakara. Ifakara had to be established as a different symbol, and what set it apart was exactly the aspect of health. Swiss power in developing health care came to be symbolized in Ifakara. Even non-medical applications would refer to the medical brand, and the dispensability of further explanations about the location in explaining the setting of a project.[123] The approach in Ifakara was branded "development on the spot" by the Geigy and his contributors.[124]

The notion of the "spot" highlights a basic truth which the Swiss Missionaries had long been aware of: even those with allegedly no colonial past needed to feel a connection with the ground. While Ifakara became more "Swiss" than it had ever been before, the notion of the "spot" (in the rural area) became important to the discourse about development practice. The spot was Ifakara and the RAC established Ifakara as a centre for medical training, which was based on the idea of a rural field where knowledge was applied and tested. This spot was now firmly enlisted in a national perspective. Instead of bringing Africans to the metropolitan institutions of learning, the training would happen in a location relevant for local development and with a curriculum and aim that was appropriate to the needs and potentials of the nation.

Thierry Freyvogel, in charge of the STIFL at the time and later to become Geigy's successor at the head of the Swiss Tropical Institute in Basel, presented the argument to a congress of Malaria experts in Rio: "Ifakara is situated in the very neighborhood of the nearly untouched bush, the biotope of game and of different Glossina species".[125] If Tanganyika was indeed pursuing new, rural strategies in the development of health, Ifakara was presented by the Swiss Tropical Institute as a prime location with laboratory qualities: "The so-called 'rural health' can only be understood in this rural situation [of Ifakara]."[126] This extended even to the African students, as the Ifakara institutions were presented as a sort of field station for the medical training schools in Dar es Salaam where students could be "trained under conditions similar to the ones they will encounter in their practice."[127]

## Swissness, bourgeois culture and the ideology of development

For the St. Francis Hospital, the establishment of the RAC turned out to be a great asset. From the spiritual point of view, there was a possibility for the Mission to work with (at least)

[123] An example: BAR E2200.83(B) 1983/27 771.24.1: *Letter [Diocese of Mahenge?] to DftZ. 19.01.1967*.
[124] ag, *Schweizerische Entwicklungshilfe in Tanganyika*, NZZ, 23.06.1961; ASTIBS 6/1/2: Ifakara I/BSFEL: BSFEL, *Die Basler Stiftung zur Förderung von Entwicklungsländern [image brochure text for Expo 1963]*. Rudolf Geigy, *Training on the spot. Swiss development aid in Tanzania, 1960-1976*, in acta tropica, 1976. ASTIBS 6/1/2: Ifakara I/BSFEL: BSFEL, *BSFEL, Protokolle der Sitzungen des Stiftungsrates, 1960-1978*, Board meeting of the 28.23.1977.
[125] Thierry A. Freyvogel, *The Work at the Rural Aid Centre (R.A.C.) Ifakara, Tanganyika*, in Acta Tropica, 1964.
[126] BAR E2200.83 (A) 1983/26 B.8.: Rudolf Geigy, *Letter to Dr. R. Schenkel, Royal Colleage Nairobi. Ifakara 23.09.1963*.
[127] ASTIBS 6/1/2: Ifakara I/BSFEL: BSFEL, *Die Basler Stiftung zur Förderung von Entwicklungsländern [image brochure text for Expo 1963]*.

the Catholic students of the RAC who were meant to become a secular rural elite.[128] Medically, the hospital profited from the staff hired for the RAC as well as their students who also worked in the hospital. The combination of clinical and training environment was a great resource for the hospital. For training courses at the RAC, the hospital offered the clinical environment, and in exchange profited from the work the students did at the hospital – particularly from the 1970s when the RAC had become the MATC.

These connections proved to be valuable in the longer term, as they kept the hospital inside a network of secular, technical development cooperation.[129] Ifakara became a place where the unity of the Tanganyikan and Swiss engagement for Development as well as the unity of the secular and religious engagement could be officially celebrated. Rudolf Geigy spoke to the mission staff about mission and development aid and the need to take joint action. "It was so cozy [heimelig]", the St. Francis Hospital chronicle commented.[130] Swiss diplomatic staff travelled to Ifakara as did Julius Nyerere who visited in October 1961 both the RAC and the St. Francis Hospital.[131]

But there were obvious tensions between the young nation, with its sympathy for socialist politics, and the conservative and liberal Swiss presence in the country. Partly, it was these tensions which opened the field for private actors in Development. Swiss diplomatic staff and development cooperation workers perceived fears in the Swiss colony, mainly about nationalization.[132] The problem with Tanzania, especially from the mid-1960s, was Chinese socialist influence, according to a report on the possibilities for Swiss development cooperation work. The report suggested that it was better to choose a project for Tanzania which could be quickly realized and was close to the ordinary citizen's needs.[133] There was no need for official Switzerland to burn its fingers with a socialist government and it was suggested by the Swiss Ambassador that it would be better for the Swiss government to send its own development experts "to other countries where there were no missions", because in Tanzania Swiss knowledge and contribution to the development of agriculture was already well represented.[134]

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[128] PADSM Box 17, Mahenge Diocese 2: *Protokoll über die Konferenz der Dekane der Erzdiözese DSM. Ifakara 09.08.1961*.
[129] A. Gsell, *Basel kämpft gemeinsam mit Tanganjika gegen Unwissenheit und Krankheit*, Ringier's Unterhaltungsblätter, 10.02.1962. Lukas Meier, *Macht des Empfängers*, 2014.
[130] Sr. Sara, *Chronik des St. Francis Mission Hospital Ifakara*.
[131] PADSM Box 153: *Chronica V [Capuchin Mission Ifakara]*, entries between July and December 1961. BAR E2200.83 (A) 1983/26 C 9.1.: Rudolf Geigy, *Letter to Consul Diener. Ifakara 20.08.1961*.
[132] BAR E2200.83 (B) 1983/27 110.9: H.K. Frey, *[Report on visit to Swiss colonies in Mombasa, Tanga and Arusha-Moshi 13.10.1966-21.10.1966] 24.10.1966*. Amboni came under considerable pressure but was handled comparatively soft. Le, *Die staatliche Zwangsjacke in Tansania - ein Gewebe aus Idealismus und Dilettantismus*, NZZ, 20.05.1967. Hanan Sabea, *Reviving the Dead*, in Africa, 2001. In the 1970s the reduction of development cooperation payments were discussed as possible "measure of retorsion" against nationalization: BAR E2200.83 (B) 1993/303 771.20: Marcel Heimo, *Notiz an die politische Direktion. Nationalisierungen und technische Zusammenarbeit mit Tansania*; BAR E2200.83 (B) 1993/303 771.20: Iselin et al., *Note au Délégué à la Coopéreatoin technique. Bern 15.04.1975*.
[133] BAR E2005(A) 1978/137 t.311. Tanzania Projekte und Aktionen: DftZ et al., *Aktennotiz über die Besprechung mit Herrn Lindt betreffend Abklärungsmission in Tanzania und Malawi. Bern 15.07.1965*.
[134] BAR E2200.83 (B) 1983/27 771.20: Marcel Luy, *Letter to EPD DtfZ. DSM 25.06.1966*. On the other hand the Capuchin mission, who ran a couple of institutions in the sectors listed for possible projects, did not figure as a possible partner: BAR E2005(A) 1978/137 t.311. Tanzania Projekte und Aktionen: DftZ et al., *Überlegungen zur Abklärungsmission in Tanzania.*

The Mission looked on the new independent state with a mixture of fear and fondness for the people and the country.[135] There was a strong element of paternalism in the missionaries' views on decolonization. Missionaries had been praying for "our dear black people" because African ideas about self-government were, in the eyes of the missionary, "as if a rickety child was made to pull the plough."[136] These fears were intrinsically woven with fondness, for a people who were:

> "badly represented in the Western press – but what do these armchair people and narrow-minded Swiss, who have never glanced the width of the Ulanga, who have never witnessed the endless selection of the most beautiful human beings form all continents in Dar es Salaam – what do they know about the peace and freedom man can enjoy in the most simple manner?"[137]

The missionaries were cautious, but they were also quickly drawn into the fervour for nation-building through 'self-help' and Development.[138]

One of the missionaries used the discourse of grassroots 'democracy' when he was drawn into local political conflict and was told in no unclear terms that missionaries were to keep out of politics, at least when TANU, the Tanganyika National party, was involved.[139] Still, the Missionaries had a comparatively positive view of the Tanzanian nation. In 1962 or very early in 1963, the Capuchin held an "Ujamaa conference" in Kwiro where they decided to push Africanization, revitalize the work at the grassroots level, and improve the training of the brethren sent from Switzerland (in particular, to give better professional training in crafts).[140] The Mission would subsequently not abandon this political line. In the late 1960s, it was Walter Bühlmann who handed 15 copies of the "Arusha Declaration of TANU" to the Swiss Federal Councilor, Willy Spühler, one of the seven people at the head of the Swiss federal government, in anticipation of an unofficial visit by the Federal Councilor in Tanzania in mid 1969.[141] By that

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*31.05.1965*. BAR E2005(A) 1978/137 t.311. Tanzania Projekte und Aktionen: DftZ et al., *Aktennotz: Projekt und Projekt-Vorschläge, die wir an Ort und Stelle zu prüfen versprachen. 26.05.1965*.

[135] P. Hilmar Pfenniger, *Drohen Hammer und Sichel?*, in Missionsbote der Schweizer Kapuziner in Afrika, 1962; P. Hilmar Pfenniger, *Republik Tanganyika*, in Missionsbote der Schweizer Kapuziner in Afrika, 1963.

[136] Sr. Pankratia Stumpf, *Bericht aus Ifakara*, in Providentia, 1959. The important Swiss newspaper NZZ did not report too negatively about independence: Sh, *Tanganjika wird unabhängig*, NZZ, 09.12.1961; E.M., *Tanganjika vor der Selbstverwaltung*, NZZ, 26.03.1960 - Morgenausgabe.

[137] PA Widmer Documents re Evangelizzazione e opere per lo sviluppo: P. Gallus Steiner, *Letter to E.Widmer, DSM Ostermontag 1967*.

[138] For African sisters for example had joined TANU but were requested not to pay their memberships, so that they might be dropped from the membership list quietly. DAK folder "archbishop DSM Yan'61-Mei'65": Edgar Bishop Maranta, *Letter to Pater Gallus, Dar es Salaam, 14.03.1964*.

[139] An example in Kiberege where mission teachers were also involved: PADSM 357 Govt. of Tanzania. Regiona, district and local govt. Mahenge: RC Eastern Region, *Letter to "Dear Father. [Cyprian], re. A.N. Congress Acitivities in Kiberege. 28.05.1962*; PADSM 357 Govt. of Tanzania. Regiona, district and local govt. Mahenge: P. Cyprian *Letter to Dear Sir, not dated*; PADSM 357 Govt. of Tanzania. Regiona, district and local govt. Mahenge: Elias Mchonde, *Letter to A. Mwampondele, Area Commissoiner, Ulanga. Kwiro 12.07.1962*.

[140] PADSM Box 17, Mahenge Diocese 2: *Dekanat Kwiro. 10. Dekanatkonferenz: 05.02.1963*. For the Capuchins's positions in the 1960s see: Isidor Peterhans, ed. *Katholische Kirche*, 1974.

[141] BAR E2005(A) 1980/82 t.311 Tansania: *file*, 27.05.1969, comments by B. on the Declaration were read by a number of staff at DftZ. The Capuchins remained loyal to the Tanzanian state ideology: Ordenskommission der Franziskaner (OFMCap.), *Kasita-Erklärung*, in ite, 1970.

time, Maranta saw the leftward turn of 1967 as no substantial threat for the Mission.[142] The Mission was now strongly woven into the national discourse on Development. At their mission station in Msimbazi on the outskirts of Dar es Salaam, the Capuchins had established an impressive "Social Centre", which became a locus of considerable national interest.[143] These projects were now influenced by African voices. Elias Mchonde engaged in self-help activities and most notably since 1958 as the initiator of the Ulanga Trading Union (later Trading Company) which became an economic power in Mahenge and the peripheral parts of Ulanga and explicitly tried break the 'Indian' influence over African trade. In the late 1960s, Walbert Bühlmann succeeded in bringing in the DftZ in an attempt to save the Company.[144]

Likewise Geigy – who saw decolonization as a "huge experiment of mankind" – believed that it consisted mainly in establishing a new middle class of educated professionals "who with its thousands of hands and brains" can serve a solid, modern state.[145] His rule of thumb was that "the less developed the middle classes and the larger the mass of the lower classes, the bigger the need for the country in question to receive help from abroad." These ideas about the social mechanics of development on which the RAC floated were not so new. In particular, the ideas about the establishment of an intermediate elite had long been a typical effect and aim of the missionary enterprise and was being pursued with renewed energy in the 1950s as we have seen in chapter 7.[146]

Switzerland was particularly well placed to assist in this middle class oriented scheme of help for self-help. Even if Switzerland's 'non-colonial past' went unnoticed by the African masses, the Swiss considered themselves capable of "hitting the right tone" easily – a tone which was imagined to be less authoritarian than that of the traditional colonialist.[147]

Like the Tuberculosis hospital, the RAC became another showpiece for development work in Switzerland. Through the work at the RAC, but also at the Mission Hospital, Ifakara was quickly becoming a public "showcase".[148] At the Swiss national exposition EXPO64 the BSFEL presented its activities in Ifakara to a wide audience. The Swiss visitors at the exposition learnt

[142] PA Widmer Documents re Evangelizzazione e opere per lo sviluppo: Edgar Maranta, *Letter to E.Widmer, DSM 14.03.1968*. The Swiss Benedictines in Tanzania even published a 'primer' on citizenship for Tanzanians: Hildebrand Meienberg, *Tanzanian citizen. A civics textbook*, 1966.
[143] BAR E2003-03 (-) 1976/44 t.941.1 Tanganyika: Lukas Gämperle, *Letter Tanzanian Episcopal Conference to Dftz. DSM 01.03.1962*. BAR E2200.83 (A) 1983/26 B.8.: Lukas Gämperle, *Letter to Schweiz. Delegierter für Techn. Zusammenarbeit. Jumba la Maendeleo Msimbazi, 21.10.1963*. BAR E2005(A) 1978/137 t.311. Tanzania Projekte und Aktionen: Marlies Bucher, *Letter to Gander. Neuenkirch 07.02.1964*.
[144] P. Hilmar Pfenniger, *Selbsthilfe. Ein Interview mit Msgr. Elias Mchonde*, in Missionsbote der Schweizer Kapuziner in Afrika, 1963. BAR E2200.83(B) 1983/27 771.24.1: [file], *Experten für Genossenschaft Ulanga, Kwiro [UTC]*. In 1972 UTC had a practical monopoly in the Mahenge area on sugar and fuel, and it was the major purveyor of consumer goods to something like 30-40'000 people in the area. BAR E2200.83(B) 1990/26 771.24.1: Dannecker, *Letter Swiss Embassy DSM to DftZ. 19.07.1972*.
[145] Rudolf Geigy, *Der Sprung in die Selbständigkeit (Entwicklungshilfe und Menschheitsproblem)*, 1962, pp. 5, 19.
[146] Walbert Bühlmann shared the idea of the need for the development of a middle class. Walbert Bühlmann, *Afrika*, 1963, p. 201.
[147] Rudolf Geigy, *Erfahrungen bei der Begegnung mit Vertretern fremder Kulturen*, in Acta Tropica, 1964, pp. 390, 393-394. PA Freyvogel Thierry A. Freyvogel, *Ausführliche Stichworte zu den Vorträgen: 'Afrika im Brennpunkt' (Stäfa 03.02.1959) und 'zwischen Afrikanern und Europäern' (Basel Bernoullianum 05.02.1959)*.
[148] Jürg Bürgi et al., *Mehr geben, weniger nehmen*, 2004, p. 157.

that the "complicated experiment in education" with the young Africans was a success from the beginning, and that the Tanganyikan Government had already charged it with training 'Medical Assistants" into "Assistant Medical Officers.[149] Ifakara became the spot where the Swiss contributed to the message of the hour, which was that Tanganyika needed to make swift progress. Cooperation would allow Tanganyika to jump out of the Stone Age and modernize much quicker than European societies had done in the past. The road to progress had to include a total perspective on health in the community, and appropriate training.[150] Ifakara became the spot where "Basel fights side by side with Tanganyika against ignorance and disease" as the title of a newspaper article declared.[151]

Ifakara thus reinforced national sentiment in Switzerland, and Swiss identity remained strong in St. Francis Hospital. English was the language of professional medicine in the early 1960s, according to a doctor, but German was important as a language spoken between those with managerial power at the SFH and also between Swiss nuns and Swiss nurses.[152] A sort of a mission-style Kiswahili was the main language to converse with patients, and also increasingly in the hospital.[153] The Swiss national holiday on 1 August was celebrated by a large gathering of the community.[154] Increasingly, Ifakara was reported as being a "piece of Switzerland" abroad, Ulanga jestfully dubbed the "Kanton Kilombero".[155] Even a "convinced Protestant" applauded the work of the Capuchin mission, a testimony that Swiss nationality had overcome the confessional rift.[156]

To missionary lobbyists and reformists in Switzerland and notably to Walbert Bühlmann, in this situation of entwined national and private motives, it seemed both possible and correct to claim that development aid was an invention and a long-term practice of the Mission, which had indeed no patent on the idea but now could reasonably hope to win support for its activities from the coffers of the Swiss Development Cooperation. The Catholic mission promoters in general, and along with them the SKMV, now reinvented their history into a long tradition of humanitarian and development aid to the "underdeveloped peoples". And now they would do development even more efficiently, they claimed.[157]

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[149] ASTIBS 6/1/2: Ifakara I/BSFEL: BSFEL, *Die Basler Stiftung zur Förderung von Entwicklungsländern [image brochure text for Expo 1963]*.
[150] Herzig, *Schweizerische Entwicklungshilfe in Tanganjika*, in Gewerkschaftliche Rundschau: Vierteljahresschrift des Schweizerischen Gewerkschaftsbundes, 1964. George MacDonald, *The Development of Health Services in Tropical Countries*, in Acta Tropica, 1963.
[151] A. Gsell, *Basel kämpft gemeinsam mit Tanganjika gegen Unwissenheit und Krankheit*, Ringier's Unterhaltungsblätter, 10.02.1962.
[152] *Interviews with Edgar Widmer, Thalwil, 23.10.2008 und 27.10.2008*.
[153] Isolde Schaad, *Knowhow am Kilimandscharo*, 1984, pp. 109-112.
[154] Sr. Blasia Zihlmann, *Gruss aus Ifakara*, in Providentia, 1964. In 1968 the mission ordered one hundred first of August badges for Kwiro: BAR E2200.83 (B) 1983/27 110.512: *1.August-Abzeichen 1968*.
[155] E.M. Zimmermann, *Impressionen von einer Ostafrikareise. 1. Folge*, in Tam-Tam, 1965. E.M., *Tanganjika vor der Selbstverwaltung*, NZZ, 26.03.1960 - Morgenausgabe. A district in Switzerland with its own regional government is called a Kanton.
[156] Erwin Beglinger, *Schweizer in Tanzania*, Basler Volksblatt, 29.12.1967.
[157] SKMV, *Jahresbericht 1963 des SKMV*, in Missionsärztliche Caritas, 1963.

## The missions as an agency of development

Even though development projects were complicated and rarely worked according to plan, Ifakara was a place where an intensive and likely long-term engagement was imaginable. The positive reports coming back from Ifakara at that time were numerous. Just as numerous were the Swiss who went for visits to Ifakara, to see the 'showpiece in the bush'.[158] Ifakara was not only a pivot for development cooperation in Tanzania, it also became the hub for an argument about the role of the churches and missions in Switzerland's development aid. When Switzerland started its government development cooperation, the Catholic mission was quick to present their contribution to the development of Africa as reaching back into times before the new idea of 'development cooperation' had even been coined, and, additionally, as more efficient and powerful now than most of newer forms of state-based development. Swiss missionaries and Swiss secular proponents of Development in Ifakara mutually acclaimed their development activities. Not only did Ifakara feature in the debates in the Swiss federal parliament about development cooperation, the missionary organizations had also mobilized parliamentarians from Bern to testify to the work of the Capuchin mission in Ifakara, notably the hospital, as examples of the impressive achievements of the church in Development.[159]

Even from the time of colonial rule, the Capuchin mission argued, their contribution to social and economic life had contributed to the "quiet and healthy development of the country."[160] In the course of their history, the missions in Switzerland collectively claimed, they had "always had reason to start institutions which were materially equal to development aid. [...] These activities had always promoted the entire population and not only the Catholic segments of society."[161] Missions presented themselves to have the 'consistency of granite' and to be entirely coalesced with the local people and therefore fully flexible to adapt to new political environment.[162] At the moment of independence in Tanganyika, the Catholic missions claimed that they ran 250 dispensaries, 70 hospitals and cared for 3 million patients annually.[163]

Walbert Bühlmann stood at the frontline to lobby about mission development work *avant la lettre*. In 1960, he argued that Catholic Switzerland contributed financially as much to

[158] Erich Zimmermann, a central figure of the Swiss African Club reported from a "trip to East Africa" in 1965: E.M. Zimmermann, *Impressionen von einer Ostafrikareise. 1. Folge*, in Tam-Tam, 1965. Stanley Hubbard, *Augenschein in Ifakara beispielhafte Entwicklungshilfe der Basler Chemie*, in Ciba-Geigy Zeitschrift, 1975. Cécile Koechlin et al., *Der Buschdoktor von Ifakara*, 1978; ASTIBS 6/1/2: Ifakara I/BSFEL: BSFEL, *Die Basler Stiftung zur Förderung von Entwicklungsländern [image brochure text for Expo 1963]*. Herzig, *Schweizerische Entwicklungshilfe in Tanganjika*, in Gewerkschaftliche Rundschau: Vierteljahresschrift des Schweizerischen Gewerkschaftsbundes, 1964. H. Rentsch, *Die technische Zusammenarbeit der Schweiz mit afrikanischen Ländern*, in Afrika Heute, 1964.

[159] Schweizerische Eidgenossenschaft, *Ständerat: Geschäft 8052 Interpellation Mäder. Technische Hilfe an Entwicklungsländer*, Amtliches Bulletin der Bundesversammlung (1960). Sten Bull StR IV/1960, 291.

[160] Karl Schöpf, *Das Spital von Ifakara*, in Missionsbote der Schweizer Kapuziner in Afrika, 1957.

[161] BAR E2003-03(0) 1976/44 t.912.5-(101): M. Blöchlinger, *Memorandum*.

[162] Walbert Bühlmann, *ite interview: Dr. Wilhelm Meile*, in ite, 1965.

[163] Walbert Bühlmann, *Die Schweiz hilft den Entwicklungsländern: Der Beitrag der kath. Missionen*, in katholisches Missionsjahrbuch der Schweiz, 1960, p. 12.

development as the young (and at that time quite limited) offices of the Swiss federal state.[164] The missions were putting pressure on the DftZ to accept the mission projects as eligible for funding.[165] In 1961, Bühlmann met with the director of the DftZ and presented a series of mission projects. "It was a hit," Bühlmann reported in his memoirs, and indeed his lobbying paid dividends.[166] The DftZ collected the numbers for mission engagements and included these in the report to the Swiss parliament.[167] The director of DftZ subsequently wrote to Bühlmann in 1963:

> "A long time before the term 'development aid" had been coined, the Christian missions in Africa [...] have labored in the field of education and training in the sense of development cooperation in the best manner [...] and it is a an example from which government activities can learn." [168]

The federal government soon sought the support of the Swiss churches for the political discussion of the next financial outlay for development cooperation. The DftZ, Protestant missions and Walbert Bühlmann together presented their case at a media conference, now stating that the church engagement in development aid was large and still growing. They stressed that the missionaries had great technical expertise, knew the national and local languages as well as the country, had long-standing relations with the locals, were motivated, worked within small budgets and, not least, were already on the spot and did not need to be recruited.[169] These arguments remained prevalent in the discourse for a long time. In 1968, the Catholic Medical Mission Association (SKMV) claimed that the association's work was better than the rest in medical development cooperation.[170] Additionally, it was held that the SKMV and the Catholic volunteers represented Switzerland well, not least because of their desire for quality in workmanship.[171] Organizations from the missionary movement like the SKMV now also subscribed to the terms of national development in a sustained perspective with "projects which work towards the attainments of self-help and self-reliance."[172]

The re-invention of *Kulturarbeit* as Development was a modernization of mission which helped to adapt mission work to the contemporary situation both in Switzerland as in Tanzania.

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[164] Walbert Bühlmann, *Die Schweiz hilft den Entwicklungsländern: Der Beitrag der kath. Missionen*, in katholisches Missionsjahrbuch der Schweiz, 1960.

[165] For an example see: BAR E2003-03(0) 1976/44 t.912.5-(101). *Note au Chef du Département. Bern 18.07.1960*. BAR E2003-03(0) 1976/44 t. t.912.5-(101). DftZ, *Letter to Basler Mission. F.Raaflaub. Bern 23.11.1960*.

[166] Walbert Bühlmann, *Überraschungen meines Lebens*, 1994, pp. 36-37.

[167] BAR E2003-03(0) 1976/44 t.912.1: DftZ, *Zusammenfassung der privaten schweizerischen Leistungen auf dem Gebiete der technischen Entwicklungshilfe. Bern 15.03.1961*. Schweizerische Eidgenossenschaft, *Botschaft des Bundesrates an die Bundesversammlung über die Zusammenarbeit der Schweiz mit den Entwicklungsländern (vom 05.05.1961)*, Bundesblatt (Bern1961). Albert Matzinger, *Anfänge*, 1991, p. 199 stated that the Message by the Federal Council had already been drafted at the time of Mäder's Interpellation. I have not checked the exact chronology of the drafting of these documents.

[168] August R. Lindt et al., *Letter to W. Bühlmann, SKAMB. Bern 04.05.1963*, in Katholisches Missionsjahrbuch der Schweiz, 1963. See also the original document in BAR E2003-03(0) t. t.912.5-(101) showing that this text was created in response to Bühlmann had asked for a statement to be used in the Mission Yearbook.

[169] BAR E2005(A) 1978/137 t.751-005: Rolf Wilhelm, *Notiz an Herrn Lindt: 'Missionen und Technische Zusammenarbeit'. 18.11.1964*.

[170] SKMV, *Jahresbericht 1968 des SKMV*, in Missionsärztliche Caritas, 1968.

[171] BAR E2005(A) 1978/137 t.751.007(7): Arbeitskreis Schweizerischer Jugendverbände et al., *file overview: Schweiz. Katholischer Missionsärztlicher Verein*. A "Swiss character" was also a condition for DftZ support to development projects. BAR E2003-03(0) 1976/44 t. t.912.5-(101). DftZ, *Protocole de l'entretien du 04.03.1963 entre le DftZ avec Blöschlinger, Bühlmann et Plattner. Bern 26.03 1963*.

[172] SKMV, *Jahresbericht 1960 des SKMV*, in Missionsärztliche Caritas, 1960.

Collecting money for their Development projects helped to solve some of the financial challenges the missions faced in the early 1960s.[173] Not least, 'project'-related funding had the potential to carry the existing relations with long-time donors to the mission cause into the era of locally-led churches.[174] Notably, it was hoped that these 'traditional' donations could be combined with the secular monies that came to replace the colonial grants-in-aid to medical service. In Tanganyika, however, the mission's claim to development assistance was challenged. Missions had built clientelistic relations for decades and the paternalism of mission was still palpable at the time. The Mission claimed to have entered in an "honest, disinterested cooperation" with Africans.[175] In the eyes of nationalist and anti-colonialists, such claims were scarcely credible.[176] As Africanization took centre stage in national politics, the slow transfer of power in the Church institutions stirred conflict.[177]

Neither was the idea of mission as Development accepted without question in Switzerland. In a foundational analytical work of the conception of development cooperation, Walter Renschler argued that the religious was present in development cooperation in two forms: in the 'Christian-moral' form, Development was based in the Judaeo-Christian moral tradition but had secular aims; the "Christian-missionary' form on the other hand aimed at conversion to the Christian faith.[178] Indeed, mission scientists like Walbert Bühlmann held that plain, secular development aid must not be allowed to eclipse the ultimate goal of mission.[179] Mission was, in the formula of Bühlmann, development cooperation with a message of peace, righteousness and rejoicing in the Holy Spirit.[180] Bühlmann's and Renschler's academic arguments were based more on the identity politics of Catholicism and of development discourse and, in Switzerland, including those who sought to free themselves from the conservative separatist and anti-secular Catholic culture in Switzerland[181], than they were based on happenings in contemporary Tanzania. There, the mission very actively acted within the framework of the secular state, and indeed contributed for a long time to the establishment of

[173] Annett Heinl et al., *Spendenfinanzierte private Entwicklungshilfe in der Bundesrepublik Deutschland*, 2009.
[174] It must be said that the Capuchin Mission until the late 1960s had little success in touching DftZ money for their projects. The social centre in Msimbazi was an important project in this respect, because it occupied an important place for meetings for the national political organizations like TANU, NUTA etc, but in 1967 the Capuchins were not listed as recipients: BAR E2200.83(B) 1983/27 771.20
E2200.83(B) 1990/26 t.771.20: Peter A. Wiesmann, *Rapport über die Abklärungsmission in Tanzania 05.09.1965-29.09.1965*; BAR E2005(A) 1980/82 t.751-7: DftZ, *Project d'institutions suisses confessionelles beneficiaires d'une contribution federale*.
[175] *Uhuru*, in Missionsbote der Schweizer Kapuziner in Afrika, 1960; P. Gallus Steiner, *50 Jahre Mission Ifakara*, in Missionsbote der Schweizer Kapuziner in Afrika, 1962.
[176] Walter Rodney described missionaries as "experts on the side of cultural imperialism": Walter Rodney, *How Europe underdeveloped Africa*, 1981 [1972].
[177] John Iliffe, *Modern History of Tanganyika*, 1979, pp. 507, 542, 573-504. Eckert, *Herrschen und Verwalten: Afrikanische Bürokraten, staatliche Ordnung und Politik in Tanzania, 1920-1970*. pp. 80, 170f, 226.
[178] Walter Emil Renschler, *Konzeption der technischen Zusammenarbeit*, 1966, pp. 29ff, 64ff.
[179] Walbert Bühlmann, *Afrika*, 1963, pp. 51-52.
[180] Walbert Bühlmann, *Der Beitrag der katholischen Mission zur Entwicklung des Tanganjika [sic!]*, in Schweizer Monatshefte, 1961/62, p. 451.
[181] An example is Pia Holenstein, another key figure in Swiss development cooperation. See her memories on her Catholic background in Anne-Marie Holenstein-Hasler et al., *Entwicklung heisst Befreiung*, 2008, pp. 18-19.

the basic infrastructure needed for a developmentalist state. In Bühlmanns eyes, this was excessively so because the Brickstone-mission[182] of the past had produced "heaps of stones" in the shape of hospitals and huge churches.[183] But had it led to a moral re-invention of the African? This was Bühlmann's implicit question. To a reader today, it is striking to see how much of the 'missionary' discourse in Bühlmann's argument is, in fact, about morals, and reflects todays's development cooperation preoccupation with 'good governance': "The Christian world-view," Bühlmann wrote, "is important for the basic problems the developing countries face [...] which turn around working 'better' [meaning with care and efficiency] and reducing corruption". Nyerere, Bühlmann went on, was clearly seeing this and building it into the foundation of the state ideology.

## Ownership: The End of the Late-Colonial Period

In 1964 the Diocese of Mahenge, largely equivalent to the political and administrative District of Ulanga, was partitioned from the Archdiocese of Dar es Salaam and Bishop Elias Mchonde became the head of the new Diocese. This move had been prepared since 1961 and a number of Capuchins remained central figures in the church in both Dioceses.[184] The transformation of mission into church was part of the process of decolonization in Africa. Pressure to Africanize the church bodies in the 1960s had its impact on the St. Francis Mission Hospital, as it brought a considerable change of ownership and management structures, even though they were not revolutionary and no new flags were hoisted.

The presence of the hospital affected the structure of the new Diocese of Mahenge in important ways, not least by its weight in the Diocesan budget. One of the Capuchins saw the hospital as the "most dangerous trouble spots" in the Mission produced by the separation of the Mahenge diocese.[185] The conflicts were not racial but inter-Diocesan and the major outcome of the struggles over control was the establishment of formal bodies of hospital management and contractual relations with its supporters. Before the end of the decade, the Diocese of Mahenge – trying to get a grip on the hospital mainly in order to check the financial risks of the hospital sapping on the Diocesan resources – curtailed the influence of the two leading figures in the hospital, Bishop Edgar and Doctor Schöpf to the point where they quit the deck. The era of

[182] "Brick-stone mission" described the Mission founded on the establishment of literally strongly built institutions as base for mission activity: Siegfried Hertlein, *Wege christlicher Verkündigung*, 1983, p. 51.
[183] Walbert Bühlmann, *Afrika*, 1963, p. 300 and for the rest of this paragraph p. 187-189 (on 'working better' as 'caritas see pp. 296-298)
[184] PADSM Box 17, Mahenge Diocese 2: *Protokoll über die Konferenz der Dekane der Erzdiözese DSM. Ifakara 09.08.1961*. P. Donat Müller, *ite Lagebericht*, in ite, 1965. PADSM 20/Mahenge Diocese 20 History: Callistus Mdai, *Diocese of Mahenge: Sketchy Notes on the History of the Diocese*. Fr. Deogratias H. Mbiku, ed. *Historia ya Jimbo kuu la Dar es Salaam*, 1985. At the same time a debate started about the creation of a Kilombero district, with Ifakara as its administrative capital Tanganyika Legislative Council, *Council Debates [Hansard] Official Report*, 1965.
[185] PAL Sch 1060.3: P. Hilmar Pfenniger, *Letter to P. Provinzial. Sursee, 28.10.1964*.

almost total personalized control over the hospital was ended, and also, at least formally, the state was allowed to sit in the newly formed Board of Governors.

In March 1964, Maranta also made a new contract with Schöpf.[186] In addition, he urged the Baldegg sisters to enter into a formal contract with Bishop Elias, because he felt that it would prove "absolutely necessary to have precise regulations for the time when the majority [in the governing bodies of the Church] will be Africans."[187] Maranta also tried to keep some influence in the hospital which now fell under the Diocese of Mahenge. His motives seem to have come from an attachment to what had been accomplished in Ifakara and especially at the hospital and from his loyalty to Dr. Schöpf. Maranta also felt a sense of duty to honour the financial engagement he had entered and which he seems to have taken on because of the personal responsibility he felt towards the institution. Therefore, rather than just handing the hospital over to the care of Bishop Elias in Kwiro, Maranta kept not just a watchful eye over the hospital, but also his purse open. However, discretionary power over the purse had changed in the 1960s. Maranta found it difficult – some missionaries felt – to accept a more 'democratic' voice in the (financial) management of the Church.[188]

Maranta had been willing to continue taking the responsibility for financing SFH and he assumed he would be able to get additional funds from Switzerland for this purpose. While he spent the money, he still opposed the deduction of the money for the St. Francis Hospital from the account of the Archdiocese but automatically debited them from the funds of the Mahenge Diocese, arguing that the "hospital has been erected for the area of Mahenge in the first place and it serves almost exclusively the population of Mahenge".[189] He could do so because of the way in which the financial contributions from the Capuchins were administered: the Capuchin Province in Switzerland split its hospital contribution and left the Bishops to sort out the details.[190] In mid-1964, Maranta's critics, some of whom the Archbishop later saw as his personal 'archenemies,' were not prepared to allow Maranta to continue to reign over the hospital: "If the Diocese of Mahenge finances most of the running costs of the hospital, it should also be allowed to know what happens with the money and to correct the course of action where it seems necessary," the advisors of Bishop Elias Mchonde insisted.[191] Indeed, the hospital was weighed heavily on the Church's purse. At the end of the decade, two whole months' worth of the money transferred to the DSM Archdiocese from the Swiss Capuchins was spent on the hospital

[186] PAL Sch 1061.6: Karl Schöpf et al., *Amendment to Agreement, DSM 10.03.1964*.
[187] PAL Sch 1043/Missionssekretär & Baldegg u. einzelne Schwestern: Edgar Maranta, *Letter to Mother General Baldegg. DSM 10.06.1964*.
[188] PAL Sch 1060.3: P. Hilmar Pfenniger, *Letter to P. Provinzial. Sursee, 28.10.1964*.
[189] PAL Sch 1060.3: Edgar Maranta, *Letter to P. Provinzial. Rom, 08.11.1964*.
[190] PAL Sch 1060.3: Seraphin, *Letter to P. Donat. Luzern 09.12.1964*. Additionally, it is possible that that the money went to Dar es Salaam where it was split according to an agreed ratio between the Archdiocese and the Diocese of Mahenge. Therefore, when Maranta deducted 'his' costs for running the hospital, including the salary of Schöpf, from financial contributions set aside for Mahenge Diocese before it was transferred onward to Kwiro, the Diocese immediately felt sidelined: PAL Sch 1060.3: Deodat, *Letter to P.Hilmar. Mahenge, 21.10.1964*.
[191] PAL Sch 1060.3: Deodat, *Letter to P. Provinzial. Kasita, 22.10.1964*.

in Ifakara, and the Mahenge Diocese spent at least a seventh of its total income on the hospital deficit.[192]

In order to relieve the Church of some of the financial burden of the hospital, Maranta tried to motivate the Medical Department in Dar es Salaam to share the costs of the hospital in Ifakara. If the hospital were to be acknowledged as the official district hospital (rather than nationalized) – it would be eligible for a higher government subsidy, while remaining under the Catholic Dioceses.[193] Maranta seems to have received such a promise on the condition that a Board of Governors was constituted on which two representatives of Government would sit.[194] Against Maranta's attempts to keep the hospital under his factual control the Bishop of Mahenge now pressed to have a strong say in the establishment of the Board of Administration/Governance. Bishop Elias also acted swiftly and started to fund the hospital, "in order to assume more influence and to have their say in the composition of the Hospital Commission".[195]

This Board of Governors was not constituted before December 1966, however.[196] The Mahenge Diocese had started to develop formal bodies of corporate rule before: most notably financial and pastoral commissions, each of them a mix of Swiss missionaries, including Baldegg sisters, and a first generation of Tanzanian clerics, who remained in a minority.[197] As with these other Church committees the chairman of the Hospital Board of Governors was Bishop Elias of Mahenge. Two additional representatives of the Diocese of Mahenge and a Capuchin of Mahenge, representing the Swiss Capuchin Province, sat on the board on which Edgar Maranta was the (single) representative of the Archdiocese. The Baldegg sisters were also represented, as were the Basel Stiftung (BSFEL) and the medical faculty of the University of Basel in Switzerland through their interests in the Rural Aid Centre and two representatives of the Tanzanian Ministry of Health. Simple mathematics show that this was a very 'balanced' board in which the Swiss (secular and missionary) representation would amount to roughly half the board, which was, overall still largely religious in its composition.[198]

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[192] With a trend towards 1/5 PAL Sch 1060.3: Deodat, *Letter to P.Provincial. Kasita 02.02.1969*. PAL Sch 1060.3: Edgar Maranta, *Letter to P. Deodat. DSM 05.03.1969*.

[193] ASTIBS 6/1/2: Ifakara I/BSFEL: BSFEL, *BSFEL, Protokoll, 24.11.1964*. For the first ideas of the concept of designation see chapter 7. In 1976 the St. Francis Hospital became a Designated District Hospital: see chapter conclusion. The establishment of a hospital board including government and other non-mission representatives, was a condition for such a 'designation'. For more background see: T. W. J. Schulpen, *Integration of Church and Government Services*, 1975.

[194] PAL Sch 1060.3: Edgar Maranta, *Letter to P. Provinzial. Rom, 08.11.1964*.

[195] PAL Sch 1060.3: Deodat, *Letter to P.Seraphin, Provinzial. Mahenge, 22.12.1964*.

[196] ASTIBS 6/2/6 "S.Francis Hospital": SFH, *Board of Governors - SFH: Constitution [agreed on first meeting held 22.12.1966]*.

[197] P. Donat Müller, *ite Lagebericht*, in ite, 1965. Müller explained that this shows that Bishop Elias was "no revolutionary […] he tries to continue what has been started […] and he emphasizes good interpersonal relations. Mainly the negotiations with Government have profited much from this."

[198] ASTIBS 6/2/6 "S.Francis Hospital": SFH, *Board of Governors - SFH: Constitution [agreed on first meeting held 22.12.1966]*. PA Widmer Documents re Evangelizzazione e opere per lo sviluppo: Edgar Maranta, *Letter to E.Widmer, DSM 01.12.1966*. PADSM & PAL Box 155 Ifakara SFH 1 -7- & Sch 1060.3: Donat Müller, *Letter [Sec. Diocese of Mahenge] to P. Paskal, Mahenge 17.11.1966*. The board was not an invention of the Diocese alone, it seems it was based on a draft by the

The duties of the BoG were to

> "exercise the highest authority; meet at least once a year [..] approve the annual [...] account and the report of the director [...] discuss and approve the budget [...] consider ways and means of raising funds to meet the running costs, repairs and possible extensions of the hospital [....] appoint the [medical] director [... ] as proposed by the Foundation Body [which was the Diocese of Mahenge] [...] appoint the MOs on contract [...] nominate the executive committees of the hospital after hearing the proposals of the Foundation Body."[199]

Even before the BoG was formed, Schöpf had negotiated yet another contract with the diocese. It took a long time to reach an agreement.[200] Faced with the prospect of his return to Europe, Schöpf had asked Maranta for a better pension scheme. But Maranta refused, reminding the doctor that he had already received a salary which was higher than that of any other mission doctor in Tanzania. Moreover, this was just the sum from the Mission, in addition to which he made an income from private patients and teaching at RAC. Maranta was in the throes of an inner conflict. He felt "very close to the hospital and to those who have made it", but he was now careful not to hand over large liabilities to the Diocese of Mahenge and to his prospective successor in Dar es Salaam, who would not have any personal ties to the Ifakara mission. Maranta knew that the times "when [he] had full control of the hospital and did not need to take heed of the critical voices" had passed.[201] For the financial commission of the Mahenge Diocese, it seemed impossible to continue the contract with Schöpf for cost reasons, and the commission reacted angrily to an attempt by the doctor to have his contract signed directly by the Swiss Capuchins in Switzerland.[202] At the time he fought for his own salary, Schöpf saw that the financial commitment of the Diocese to the hospital was at stake, as only when the Diocese had pumped enough of the money from the Capuchins into the hospital could it assure that the high standard of the hospital would be maintained.[203] Bishop Elias was reported to have a better rapport with the state officials in Tanganyika than the missionaries. But for the financial sustenance of the hospital, it was the transnational rather than the national arena which was important. The Government was of little help and Maranta blamed the Government's lack of

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Tanzanian Church Health Organization: PAL Sch 1061.6: Karl Schöpf, *Letter to AMECA representative. F. Benedict, c/o Miserior Aachen. Zams, 18.04.1966*. In late 1967 the second board meeting. Finally all parties had signed the board constitution. Maranta took the Ministry of Health signature on the constitution as a sign that even if government was not augmenting its subsidies, at least it openly stated its interest in the hospital: PA Widmer Documents re Evangelizzazione e opere per lo sviluppo: Edgar Maranta, *Letter to E.Widmer, DSM 25.09.1967*.

[199] ASTIBS 6/2/6 "S.Francis Hospital": SFH, *Board of Governors - SFH: Constitution [agreed on first meeting held 22.12.1966]*. Additionally to the BoG a executive committee was formed where the Chairman of the BoG was joined by the director of hospital as vice president, another doctor, the matron, and the administrator.

[200] PAL Sch 1061.6: *The Diocese of Mahenge with Dr. Karl Schöpf. Agreement for Service as Mission Medical Officer at Ifakara. 01.04.1966 [draft]*. PADSM Box 17 - Mahenge 4: Diocese of Mahenge et al., *Letter to P. Sebastian, Missionsökonom in Luzern. Kwiro 17.11.1966*.

[201] PAL Sch 1061.6: Edgar Maranta, *Letter to C.Schöpf. DSM 21.06.1966*. PAL Sch 1061.6: Edgar Maranta, *Letter to C.Schöpf. DSM 26.04.1966*.

[202] PAL Sch 1061.6: Edgar Maranta, *Letter to C.Schöpf. DSM 26.04.1966*. PAL Sch 1061.6: P. Donat *Letter to P. Paskal, Provinzial, 26.10.1966*.

[203] PAL Sch 1061.6: Karl Schöpf, *Letter to E. Maranta. Zams, 15.04.1966*; PAL Sch 1061.6: Karl Schöpf, *Letter to E. Maranta. Zams, 06.06.1966*. It was true: "the money the two Dioceses are using for the hospital entirly comes from the Swiss Capuchin Province: PADSM Box 155 Ifakara SFH 1 -6-: Donat Müller, *Letter [Sec. Diocese of Mahenge] to P. Viktorian, Superior regularis, Mahenge 05.10.1966*.

generosity for the seemingly 'impossible' situation he had left for his successor to sort out.[204] As a consequence, Maranta "strongly advised" Bishop Elias not to withdraw the contract with Schöpf. This could put at the risk the supply of Swiss doctors through Geigy in Basel and Lehner in Luzern, as the interest of these key figures at the head of secular institutions was crucial to the hospital to secure the services of doctors. Maranta felt that he had to remind his colleague in Mahenge about the value the hospital had for to the "population of your Diocese, which, from the point of view of public health, is in poor shape."[205] Mchonde hardly needed to be reminded of these facts. He and his advisors were aware of the crucial position of the hospital in the social welfare and development of the region.[206] But he saw himself facing a serious dilemma: "Dr. Schöpf might not agree [...] and leave us - or, we agree [...], and find ourselves obliged one day to close the hospital."[207] Mchonde reminded Schöpf that he was appreciative of his efforts, including Schöpf's fund raising in Austria, but pointed out the simple fact that to build a hospital is much easier than to be responsible for its upkeep.[208]

The solution to the dilemma was that the diocese did not cut Schöpf's salary but reduced his bonus[209] while it took firmer strategic control over the hospital and finally put the board into service. With the official argument that Bishop Elias and his councilors could not "run Ifakara hospital" on their own, the installation of a board first of all made sure that the management of the hospital was taken from the inner circle of Schöpf and Maranta, while, at the same time, it institutionalized the much needed (trans)national connections for the Mahenge Diocese as an owner of the hospital.[210] Overall, Maranta felt that that the Board was a "first step to assure the future of the hospital which has given me no small headache in the past."[211]

The first meeting of the BoG discussed the need to concentrate on the Out-Patients-Department when extending the hospital - quite in accordance with Tanzanian national health policies – to the detriment of the installation of a new clinic for gynaecology.[212] The Board thus did start to set new medical priorities. Even if considerations of general medical policy hardly seem to feature in the establishment of the new administrative set-up, they were nevertheless inherent in the processes. In time, they would become more contentious, not least because more bodies and channels came into being and different approaches to health provision were

[204] PAL Sch 1061.6: Edgar Maranta, *Letter to E. Mchonde. DSM 28.07.1966*.
[205] PAL Sch 1061.6: Edgar Maranta, *Letter to E. Mchonde. DSM 21.06.1966*.
[206] PAL Sch 1060.3: Deodat, *Letter to P.Provincial. Kasita 02.02.1969*.
[207] PAL Sch 1061.6: Bishop Elias Mchonde, *Letter to E. Maranta. Mahenge, 04.05.1966*.
[208] PAL Sch 1061.6: Bishop Elias Mchonde, *Letter to K.Schöpf. Mahenge, 21.07.1966*.
[209] PAL Sch 1061.6: Bishop Elias Mchonde, *Comments to the draft treaty between the Diocese of Mahenge and Dr. med. C. Schöpf, 14.04.1966*.
[210] PADSM & PAL Box 155 Ifakara SFH 1 -7- & Sch 1060.3: Donat Müller, *Letter [Sec. Diocese of Mahenge] to P. Paskal, Mahenge 17.11.1966*.
[211] PA Widmer Documents re Evangelizzazione e opere per lo sviluppo: Edgar Maranta, *Letter to E.Widmer, DSM 29.12.1966*.
[212] PAL Sch 1061.6: Karl Schöpf, *Letter to AMECA representative. F. Benedict, c/o Miserior Aachen. Zams, 18.04.1966*. Tanganyika Ministry of Health Chief Medical Officer, *Annual Report of the Health Division 1965. Vol 1*, 1966.

articulated by a larger group of actors. The end of Schöpf's era also put an end to the aggressive promotion of private practice in the hospital, which he had always fostered his recruitment of patients from Dar es Salaam. Surgery would remain central to the hospital's practice. A Catholic surgeon with links to Lehner and his network, Oskar Appert, would take over from Schöpf in April 1969.[213] Up to the mid-1980s, the medical director was always a surgeon. But the end of Schöpf's era in Ifakara was also the end of Archbishop Maranta's engagement there. The hospital would turn, from the early 1970s, more decisively in the direction of 'development medicine'.[214]

# Conclusion

In this chapter and in the preceding one, we have witnessed how Ifakara became a centre for the institutionalizing of 'modernizing development' in the new Tanganyikan nation as a continuation from rather than a break with the past.[215] A complex circuit of feedbacks strengthened the fundamentals of the institutions in Ifakara as this rural locale became a cornerstone on which the new relations between Switzerland and Tanganyika rested, as well as those for the Swiss claims to solidarity with the developing world. For the Mission, this period was one of transition, full of traces of the past and with portents of the future. In the words of Bühlmann, this was an "in-between-time" in which the Church in Africa was

> "thrown into a new era, that it had itself prepared, but which still has caught the Church off-guard [...] Yet the Church does not remain inactive, but approaches the challenges with new methods and fresh people."[216]

In the late 1950s and early 1960s, the Baldegg nuns, who had been sent out into 'bush' with a racially loaded mission, found themselves swept into the midst of world historical events, confronted by Africans 'bewitched' by Communism and eyewitnesses to a new era of *Uhuru*.[217] We have seen that this new era was marked by substantial up-grade of mission medical work when the Mission cast its claim for a national role into the form of a highly modern rural hospital. But the 1960s saw little de facto change in government medical policy, and the St. Francis Hospital followed the idea of modernizing development by professionalizing and extending its services on its own initiative and more or less based on the same motives that had

[213] PADSM Box 155 SFH 1 -35-: Marcel Lauber, *Letter "Lieber Pater Viktorian", St. Gallen 09.06.1968*. PAL Sch 1061.3 Ärzte etc. Verschiedenes: *[file] Dr. Appert*. St.Francis Hospital Ifakara et al., *Minutes of the third meeting of the 'Board of Governors' SFH, Ifakara 30.07.1968*, (PADSM Box 155 Ifakara SFH 21968). PAL Sch 1061.3 Ärzte etc. Verschiedenes: *[file] Dr. Appert*. On his views about Tanzania at the end of his tour: Karl Appert, Dr., *Warum in die dritte Welt? Motivierung eines Einsatzes als Arzt in einem Entwicklungsland*, in Schweizerische Ärztezeitung, 1976. Appert left his post earlier than anticipated: BAR E2200.83 (B) 1993/303 771.20: Noa Vera Zanolli, *Bericht über Dienstreise vom 17.10.1975 - 16.11.1975 nach Tansania und Äthiopien von N. Zanolli [Bern 26.11.1975, inkl. attachments dated 24.11.1975, 25.11.1975]*. Schweizerisches Tropeninstitut (Basel), *1975. 32. Jahresbericht*, 1976.

[214] PA Widmer Documents re Evangelizzazione e opere per lo sviluppo: Edgar Maranta, *Letter to E.Widmer, DSM 06.10.1968*. An article in the ite paid tribute to and marked the end of the triumvirate Schöpf/Maranta/Arnolda at Ifakara: *Abschied von Chefarzt Dr. C. Schöpf*, in ite, 1969.

[215] The German term 'aufholende Entwicklung' captures even more explicitly the idea of 'catching up' with the West.

[216] Walbert Bühlmann, *Afrika*, 1963, p. 291.

[217] P. Friedbert *Die Kirche Afrikas*, in Providentia, 1952. Walbert Bühlmann, *"Die Stunde Afrikas ist gekommen!"*, in Katholisches Missionsjahrbuch der Schweiz, 1951. P. Medard Baumgartner, *[Schreckensnachricht eins Missionärs]*, in Missionsbote der Schweizer Kapuziner in Afrika, 1951. *Uhuru*, in Missionsbote der Schweizer Kapuziner in Afrika, 1960.

driven its establishment in the late 1950s. Moreover, since the hospital remained largely untouched by the national policies of Africanization, one can almost say that the late colonial era at St. Francis Hospital lasted at least until the end of the 1960s.

There was a major change in the institutional environment of the hospital however, and this change was mainly due to the proliferation of new actors in the arena of Development. Switzerland and Tanganyika had both entered the era of bilateral development cooperation between nation states at the beginning of the 1960s. Experts in both states believed that health was important to Development, but health services did not play a large role in Swiss technical development cooperation in the 1960s. Nor did Tanganyika as a nation play an important role as a field of bilateral state cooperation in the plans of the Swiss state. As the example of the failed attempt to bring Swiss doctors into the national health system has shown, Switzerland's newly started development cooperation service had little to give to Tanganyika. In fact, the government service struggled to do any medical projects at all, and eventually waived interest in implementing medical development projects. Instead of sending its own experts and driving its own initiatives, the SDC eventually assisted in training, and sent health experts indirectly, via private organizations which had their own networks of recruitment. Many of these health experts would grow strong ties to Ifakara. As a result, private actors were given much space in the bilateral relations between Tanganyika and Switzerland and eventually these private actors made medicine and Tanganyika count in the history of Swiss Development Cooperation.[218] The proliferation of private actors who entertained transnational relations between Ulangans and Swiss considerably added to the multiplication of pastoral powers that came to mark Development in Ulanga. Development explicitly became a joint undertaking by the state together with what was called, in Tanganyikan terms, Voluntary Associations. Private actors old and new joined to create a post-colonial state which lived – at least in Ulanga – off continuities and new departures at the same time.

At the same time, Development had become a national enterprise. The new nation stipulated equity amongst its citizens. This called for the reform of medical policies. The Titmuss committee report on the medical development for Tanganyika signaled that nationalized institutions and concepts of social medicine should enter development practice and it advocated that specific institutions should be made into pillars of the nation's health policy, namely, rural community medicine and the health centre.[219] In the end, such a policy would estrange many of

[218] "From Tanzania especially we receive many applications from private organizations": BAR E2200.83(B) 1983/27 771.20 E2200.83(B) 1990/26 t.771.20: Peter A. Wiesmann, *Rapport über die Abklärungsmission in Tanzania 05.09.1965-29.09.1965*. The 1971 programme for Tanzania was firmly crafted on private activities: Schweizerische Eidgenossenschaft, *Botschaft des Bundesrates an die Bundesversammlung über die Weiterführung der technischen Zusammenarbeit der Schweiz mit den Entwicklungsländern (vom 10.11.1971)*, (Bern1971). By 1975 Tanzania was the example for health services support: Schweizerische Eidgenossenschaft, *Botschaft des Bundesrates an die Bundesversammlung über die Weiterführung der technischen Zusammenarbeit der Schweiz mit den Entwicklungsländern (vom 05.02.1975)*, (Bern1975), p. 432.

[219] African doctors were explicit about the social causes of disease in the early 1950s, see John Iliffe, *East African Doctors*, 1998, p. 107-108. Jane E. Lewis, *What Price Community Medicine*, 1986. The health centre had a longer history as the spine

the doctors with personal ambitions[220] and intricately bind Government with 'community medicine', as it took the risk of placing high quality medical services in the hands of the Voluntary Agencies. This would create all kinds of tensions, as we shall see in the next chapter, not all of them unproductive as far as the consumers were concerned.

We have also witnessed how this new era of national development activated a reconfirmation of national sentiment in Switzerland. The Swiss could discuss and test their place in the world while they sat at the table of the "Fathers House" at the mission in Ifakara and with Tanganyikan students at the Rural Aid Centre on the other side of the St. Francis Mission Hospital.[221] The fact that a place like Ifakara with an obvious missionary past became a symbol for these new engagements and even "a showcase for development" allowed the Mission to reinvent itself as a 'development agency avant la lettre'. This branding not only offered a chance to make mission work relevant to the new era. It was also needed to move the Mission out of the colonial age and, in retrospect, gave it an almost proto-national agenda. Nevertheless, that such an argument about Development was possible testifies to the continuing presence of the objects and practices of colonial development in the new post-colonial era of development. Legally, pastoral authority was devolved to the national level since independence in 1961, but many of the instruments of pastoral power were wielded by transnational networks. “Natives” had become “citizens”, but they were still considered “the poor”, as a people still regarded as being in need of education and medical charity. The colonial 'poor' were re-configured into post-colonial objects of development. The discourse of the Mission as a 'development agency avant la lettre' fitted this construction quite well as it continued *'Kulturarbeit'* in the form of development aid.

If the invention of 'development avant la lettre' by Bühlmann downplayed the history of the original proselytizing impetus, it did not do so to the point of fully contradicting the facts. Even if mission in the sense of winning souls for God's kingdom was an aspect, it was Bühlmann himself who had pushed the "Missionsjahr" in 1960 and witnessed the funds collected going into the almost purely secular TB hospital in Ifakara. The core of Development in the 1960s was modernization and Bühlmann did not shy away from claiming that the Catholic Mission had contributed more to "modern" development than the Protestant Churches, because the Catholic priests had brought so much expertise in the crafts.[222] In a hospital like the one in Ifakara, Christian morals and ethics were infused into the nation. To this aim, the missionaries were happy to create a partnership with those secular forces which joined this project. That this

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of reformist ideals propagating community health in health care planning, but also as a cost-effective means for health care delivery and there is no question that it was an inspiration for Primary Health Care it was, in the words of John Iliffe, the "fashionable panacea of the time". John Iliffe, *East African Doctors*, 1998, p. 131. Anne Digby, *Vision and Vested Interest*, in Social History of Medicine, 2008. Howard Phillips, *Grassy Park Health Centre*, 2005; Anne Digby et al., *Social Medicine and Medical Pluralism*, in Social History of Medicine, [2011] advance publication. Shula Marks, *Early Experiments*, in American Journal of Public Health, 1997; Sidney L. Kark et al., *Promoting Community Health*, 1999.

[220] Iliffe argues that the Tanzania was a special case as the small number of African doctors effectively meant that the profession was much too weak to control medical policy John Iliffe, *East African Doctors*, 1998, pp. 117, 132, 135.

[221] *Interviews with Edgar Widmer, Thalwil, 23.10.2008 und 27.10.2008*.

[222] Walbert Bühlmann, *Afrika*, 1963, p. 53.

project of Development was and still is often highly paternalist has been well-documented.[223] From its own experience, the Mission was well aware that:

> "Often the best elements amongst the awakening African are not accepting this paternalism any more. They want to carry more responsibility and they want to carry it within the framework of a modern society organized on democratic principle."[224]

Ifakara as a 'brand' in development cooperation attracted additional resources, including staff, money and lobbying support, and these resources flowed into the St. Francis Hospital. This was the legacy of a well-endowed institution, born of a late-colonial humanitarianism, which had foreseen the end of imperial paternalism. It was to be the springboard from which negotiations took place for the role of the St. Francis Hospital in Development in Ulanga.

[223] Maria Eriksson Baaz, *Paternalism of Partnership*, 2005. Hubertus Büschel, *Eine Brücke am Mount Meru*, 2009. Rebecca Marsland, *Community Participation*, in Oxford Development Studies, 2006.
[224] P. Emmeran Harder, *Bessere Felder*, in Missionsbote der Schweizer Kapuziner in Afrika, 1963, p. 47.

# Institutional Legacies: Developmentalist Medicine and the Path to Africanization

At the beginning of the 1970s, the health institutions in Ulanga entered a new era of national health planning. In the wake of TANU's *Arusha Declaration*, there was stronger state control over development planning for rural areas, which were now declared to be the very heart of the nation. The political process around the Declaration also set in motion a decisive change in health policy implementation. For some years from about 1971, the health sector received a financial boost and a central planning unit was installed with the task to plan and guide the extension of health services in the rural periphery.[1] It was the moment when the developmentalist state of Tanzania, darling of the donors already, realized the dream of the Titmuss committee, and set an example for many other developing countries. By 1975, Tanzania was becoming a model for health sector support in the name of Development.[2] From the early 1970s, expert knowledge from the fields of Medicine and Development was interwoven with the policies of the national state, and increasingly influenced the direction being taken by the St. Francis Hospital. The hospital had grown so important for health service provision in Ulanga, that it became the object of a Development intervention itself.

The nine chapters of this thesis have shown that – at the moment when Tanzania was at the forefront of new epistemes about the role and practice of medicine in developing countries –

[1] Gerardus Maria van Etten, *Rural Health Development in Tanzania*, 1976, ppp. 43-44. John Iliffe, *East African Doctors*, 1998, p. 203. Oscar Gish, *Planning the Health Sector*, 1975. Urban Jonsson, *Ideological framework and health development in Tanzania 1961-2000*, in Social Science & Medicine, 1986. Janaki N. Tschannerl, *Contemporary Health Planning Trends in Tanzania*, 1975. Malcolm Segall, *The Politics of Health in Tanzania*, 1972, p. 158.

[2] Titmuss is discussed in chapter 7/9. Schweizerische Eidgenossenschaft, *Botschaft des Bundesrates an die Bundesversammlung über die Weiterführung der technischen Zusammenarbeit der Schweiz mit den Entwicklungsländern (vom 05.02.1975)*, (Bern1975), p. 432. A Tanzanian Minister wrote a chapter in the the WHO publication on basic health services: W.K. Chagula et al., *Meeting Basic Health Needs in Tanzania*, 1975. Hans A. Baer et al., *Medical anthropology and the world system*, 2003, p. 359.

health institutions in Ulanga were already firmly enmeshed in a transnational network for a long time. Chapters 1 and 9 in particular have described how the Swiss mission was a central hub of this network. In Ulanga the Swiss had entered a diverse medical market in the name of progress and had propagated specific kinds of services in a competitive manner. The informal forms of colonial activities of the Swiss in this region were not always entirely successful. The story of the short life of the Mahenge Hospital as a Mission institution was just the most striking example of how these engagements could be caught in a web of institutional contradictions. Nonetheless, as we have seen in Chapters 2 to 4, within a larger process which established health as central issue of modernization (and for colonial government), the Mission often set medical standards for modern medicine, *dawa ya kisasa*. Chapter 5 has shown that these missionary engagements were often experienced and lived in the most intimate ways, and that they intensified debates on gender and moral economies.

By that time, the Mission was firmly based in Ulanga as a local actor with translocal connections. In Chapters 7 to 9, we have looked at how this combination of local roots and transnational base produced the St. Francis Hospital and its medical practices. In the period of decolonization, the engagement of the Catholic Church in the provision of social and medical services looked to the Mission like a key to underpin the relevance of the Church in the future nation. The Mission thus invested substantially in a flagship in the hospital sector as a gate through which the path to modernization was directed. Geared towards high standard medicine and modernizing development, the lavish hospital was quite a change from the beginnings when Sr. Arnolda's pharmacy had been presented as a model for efficiency at low cost and with basic means.[3] The new hospital provided the site in Ulanga where modern hospital medicine could be experienced and expectations about social services and welfare were formulated. Additionally it quickly became a node of Swiss discourse about Development.

Now, the beginning of the 1970s brought this new national departure in rural health care provision and connected with the rising paradigm of "social medicine" that came to be the defining discourse amongst experts of medicine and development in Switzerland.[4] These changes impacted considerably on the St. Francis Hospital and drew the Mission, by now the local Catholic Church, firmly into the orbit of new networks of medical services provision. As the hospital offered an institutional base for these networks to discuss practices and politics of rural health care provision in the era of international development, it again became the site for a negotiation about the missionary legacy in Development.

[3] Gerard Fässler, *Vom Alpstein zum Muhulu*, 1932, pp. 115-116.
[4] Lukas Meier, *Macht des Empfängers*, 2014.

## St. Francis Hospital in the 1970s

In 1968, Dr. Oskar Appert came to St. Francis Hospital and took over from Dr. Schöpf as a new medical director. He was one in a long line of surgeons at the head of the St. Francis Hospital. It was not long after Appert's arrival that an extended debate started about the role the hospital played in the health system in the Ulanga/Kilombero region. From the very first moment, Appert needed to fight against financial shortages created by cuts in the Mission and Church contributions to the hospital.[5]

Nonetheless, Appert started a number of new projects. The first to be realized was the reconstruction of the operating theatre section in the St. Francis Hospital. Appert forwarded an application for a subsidy to the Swiss Development Cooperation Services (SDC) and other donors. The needs of the Rural Aid Centre were a major argument in favour of the projected extension. Appert encountered a good number of challenges, including criticism from doctors that the extension was too ambitious. But, eventually, financing was secured and the new theatre section was put in use in early 1974.[6] At a total cost of about half a million Swiss Francs, the construction and equipment of the new operation theatre had been a costly extension. The investment was all the more noteworthy as the credo of the time was now increasingly one of cost-effectiveness across a total population. As of the young doctors at St. Francis Hospital wrote to the Bishop:

> "There is no doubt that it is much more human [sic] to fight against preventable diseases than to treat ill peoples. Preventive medicine needs money and personal engagement, but compared with the cost for treating ill people it is much cheaper."[7]

The young new doctors, who worked Ifakara in the early 1970s, quickly came to adopt Maurice King's *Medical Care in Developing Countries* as their "red bible".[8] The knowledge needed to approach health problems 'typical' to the rural districts however was not gained in training in Switzerland. On the contrary, the doctors acquired it as they experienced the actual situation in Ulanga. Exposed to the legacy of missionary discourse about charity in Ulanga and searching for ways to improve basic health provision, Dr. Per Schellenberg connected with a community of other doctors spread across Tanzania (many of them from the Netherlands) and so he found

[5] PAL Sch 1060.3: Deodat, *Letter to P.Provincial. Kasita 02.03.1969*. Oskar Appert, *Letter to: Pater Donat, Vorsitzender des B.o.G., Ifakara 03.09.1969*, (PADSM Box 155 Ifakara SFH 21969).

[6] St.Francis Hospital Ifakara et al., *Minutes of the fifth meeting of the 'Board of Governors' SFH, Ifakara [01.09.1970/02.09.1970]*, (PADSM Box 155 Ifakara SFH 2/PADSM Box 155 SFH 61970). BAR E2005(A) 1983/18 t.311 - Tansania 21: Rudolf Dannecker, *Pflichtenheft für R. Dannecker für Mission Tansania -Kenia vom 08.03.1970 - 28.03.1970*. BAR E2200.83(B) 1990/26 t.771.20: Rudolf Dannecker, *Rapport über die Mission nach Tansania - Kenia vom 08.03.1970 - 29.03.1970*. STI 6/1/1 Ordner 4: Valentin Schuppler, *Letter Ifakara 05.04.1970 to STI, R. Geigy*. St.Francis Hospital Ifakara et al., *Minutes of the sixth meeting of the 'Board of Governors' SFH, Ifakara [18.09.1971]*, (PADSM Box 155 SFH 61971). StaLu PA 572/12 Karl Appert, Dr., *Bauabrechnung per 25.05.1973 Operationssaalneubau Ifakara*. StaLu PA 572/12 Oskar Appert, *Letter to Fastenopfer. Ifakara, 18.02.1974*. BAR E2200.83 (B) 1993/303 771.20: Noa Vera Zanolli, *Bericht über Dienstreise vom 17.10.1975 - 16.11.1975 nach Tansania und Äthiopien von N. Zanolli [Bern 26.11.1975, inkl. attachments dated 24.11.1975, 25.11.1975]*.

[7] DAK folder 'hospital ifakara' in Acc. Secretary na Serikali Shelf I & III: Rüdiger Finger, *Letter to P. Iteka. Ifakara 00.03.1972*.

[8] Maurice H. King, *Medical Care in Developing Countries*, 1966. InterviewPer Schellenberg, 2011. Schellenberg reviewed the book: Per Schellenberg, *[Review] Morley, D.: Paediatric Priorities in the Developing World*, in Acta Tropica, 1974. Rüdiger Finger, *Primary Surgery*, 2011.

King's book about a year into his time in Ifakara. Based on their knowledge gained in situations like that in Ifakara,– and in the midst of a powerful wave of the invention of the 'rural' – developmentalist doctors created a medicine specifically applicable for rural areas and experts and activists in an emerging epistemic community[9] of developmentalist doctors. These developmentalist doctors were engaged experts with a social agenda, who gave, even more than Schöpf did, medical knowledge priority over matters of Church. Their major medical credo was not so much about "high-tech" medicine as it was about poverty and survival: "The problems of the nations in the Third World are not so much the tropical diseases as the diseases of poverty".[10]

The Swiss doctors in St. Francis Hospital now quickly became specialists in rural health care provision in developing countries. 'Rural' development would be the category which allowed to apply models and standardized services across diverse regions. The new generation of doctors felt that their professional task was not so much to make a hospital into a shining institution but that they had to relief suffering on a grand scale:

> "Even St. Francis Hospital looked "primitive and dirty to a new-comer from Switzerland. But you quickly get accustomed and another concern arises: does the hospital help the people in the periphery of the hospital?"[11]

In early 1974 Appert identified the current challenges for the role of the hospitals:

> "As long as hospitals are content with treating those patients who are being brought in, their effects will remain isolated. Hospitals therefore should concentrate more on the well-being of the entire population in their catchment area. With the help of mobile teams they must carry their services out to reach those who cannot come to the hospital for lack of transport; and hospitals have to engage more in preventive medicine [...] but these adjustments in the concept mean no change to the innermost idea: that mission hospitals are the answer of missionaries to the plight and needs of the sick people."[12]

With little time to spend outside the hospital theatre and wards, the doctors started to fully integrate established fields of mission medical practice, like maternal health care clinics or nutrition into the hospital medical services under the supervision of doctors. In Dr. Schellenberg's recollection, it was the experience of facing a large number of children suffering from Kwashiorkor which made him address new issues outside of his medical specialisation.[13]

Like a silent echo of its roots in the 1930s, the hospital now started a medicalised rehabilitation clinic for children who suffered from life-threatening malnutrition.[14] The clinic,

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[9] Deborah Joy Neill, *Networks in Tropical Medicine*, 2012; Peter M. Haas, *Introduction: Epistemic Communities and International Policy Coordination*, in International Organization, 1992.

[10] PA Schellenberg Folder Nutrition Promotion Muttermilch Per Schellenberg, *Stillen und Muttermilch[Manuscript for paper read in Bern, 07.04.1981]*

[11] PA Schellenberg Folder Nutrition Promotion Muttermilch Per Schellenberg, *Entwicklungshilfe aus medizinischer Sicht. Erfahrungen aus Tansania [Manuscript for paper read at Spital Limmattal, 09.05.1974]*

[12] PADSM Box 155 SFH 6: St.Francis Hospital Ifakara et al., *Jahresbericht 1973*.

[13] PA Schellenberg Folder Nutrition Promotion Muttermilch Per Schellenberg, *Notes for presentation to seminar: Medizin and Präventivmedizin in der 3. Welt [Universität Zürich, 21.06.1977]*.

[14] PA Schellenberg Folder Nutrition Promotion Muttermilch Per Schellenberg, *Letter to SKMV, H.Studer. Ifakara 03.07.1972*; PA Schellenberg Folder Nutrition Promotion Muttermilch Per Schellenberg, *Bericht über Tätigkeit in Ifakara, Tanzania 1970/73, z.H.d. polit Departementes*; *Huduma za afya zapanuliwa Ifakara*, Kiongozi, 2nd issue of May 1973. Mary Howard et al., *Hunger and Shame*, 1997, p. 183.

only one example for a series of activities including Maternal- and Child Health clinics etc, was adjusting some of the practices of missionary nuns, who had advocated the extensive use of powdered milk in their health institutions, but not necessarily produced sustained results.[15]

## Ulanga in the Early 1970s and the Role of Missionaries

The situation which the doctors experienced in Ulanga was shaped by the challenges Tanzania faced while it pushed *Ujamaa* Development. In Kilombero and Ulanga resettlement into Ujamaa villages had started from about 1969 in diverse ways: some were built from upgrading older settlements, some were reported to result from villagers initiative, some were the product of resettlements because of tsetse infestations or flooding, and from 1972/73 resettlements were notably linked with a new development: the arrival of the Uhuru train.[16] Villagization brought new medical services, but sometimes it also brought malnutrition.[17]

Some of the arguments for the villagization campaigns in Ulanga provide disturbing flashbacks to earlier chapters of this thesis, when we looked at the motives of Development by resettlement (and about bringing health services into the villages). In 1974, the Ulanga District Executive Secretary of TANU, P.S.H Mushi, was called to answer some pertinent questions in the *Daily News* column "Face the people: The column that asks the questions... and gets the answers".[18] The journalist was fairly outspoken about local “complaints“ related to the resettlement campaigns into underserviced areas. Ndugu Mushi's local government was challenged for not having been able to cope with recent floods that had cost at least 6 lives. The missionaries [sic!] had helped, the newspaper stated, long before the Government had provided help. Relations of the TANU government with the Church were great, Mushi replied: "there is the best relationship we all ever experienced. The Bishop himself, Ndugu Iteka attends most conferences and if not he sends his representative. Also the church on many occasions helps us with their cars free of charge and countless other donations." Mushi also took it as normal that “missionaries helped” in procuring food “as this is their normal gesture". The missionaries were obviously trusted as mediating modernity and cushioning its negative sides with welfare activities.

Truly, the Catholic Church, which considered Nyerere to be a trustworthy figure of continuity and progress, subscribed to the local Development initiative.[19] They followed the

[15] This was partly acknowledged in the 1970s, for example in Rosemarie Waldner, *Gesundheit der Massen als erstes Ziel*, Tages-Anzeiger, 22.04.1974.
[16] G. Kuandika, *Ulanga peasants go Ujamaa*, Daily News, 20.09.1972. Jacob Kilaudio Chitukuro, *Impact of Uhuru Railway*, 1976, p. 70. Jamie Monson, *Africa's Freedom Railway*, 2009.
[17] Reginald Mhango, *People move into planned villages along the Uhuru line*, Daily News, 16.10.1974. Simon Ileta, *Mang'ula: a spectacle on the Uhuru line*, Daily News, 19.11.1974. *Farmers: cultivate harder and with better methods*, Daily News, 16.08.1974.
[18] Anthony Beti, *Ulanga on the move to ujamaa*, Sunday News, 29.09.1974.
[19] PADSM Box 17 - Mahenge 5: *Shule ya Maendeleo ya akina mama / Kwiro*; PADSM Box 17 - Mahenge 5: P. Wolfram *Letter to Head of Dept. of Development Affairs, District Mahenge. Kwiro 26.05.1970*. Fidelis Stöckli, *Mut zur eigenen*

requests by Julius Nyerere, who – in speeches he had given in Msimbazi in 1967 or 1968 and in Mahenge on 30.10.1969 – had asked the "missionaries" and the Church to continue their support.[20] While the pastoral positions in the Church were being africanized, Nyerere "insisted that the local Bishops continue to recruit expatriate missionaries."[21] But the St. Francis Hospital had become a very large project to sustain.

## St. Francis Designated District Hospital

The former Ifakara doctor, Edgar Widmer considered that every hospital which had seen a "pioneer phase" had to eventually also enter into a phase of "consolidation".[22] Widmer was one of the persons who started lobbying in order to assist the St. Francis Hospital in its consolidation. Chapter 9 has explained how the leadership of the pioneer phase had quit the helm at the end of the 1960s. Now the Mission had to continue reducing its contributions to the hospital.[23] The prospect of sustaining the hospital was not great and with the hospital draining the coffers of the diocese, the Bishop in Kwiro/Mahenge considered handing the hospital over entirely to Government, rather than keep a hand in. The splitting of Mahenge District into Kilombero and Ulanga Districts made it unlikely that government contribution to the hospital were to rise. And any partial involvement of government would mean that services had to become free for users – meaning that a major source of income was about to collapse.[24]

At the same time, Government called for the Voluntary Associations to join the national development front and the war against "ignorance, poverty and disease".[25] Invited to give a speech at the Medicus Mundi Internationalis annual meeting in Aachen, A.H. Mwinyi spoke about "Health Planning".[26] Mwinyi explained that district hospitals were "expected to assume leadership in the total health struggle, to improve the health of all the people in the district". In five districts, it was possible for "government- and voluntary agency-staff to work together for the common good", namely where Church hospitals could become designated as District

*Lösung in Tansania*, Neue Zürcher Nachrichten, 10.12.1971. Ordenskommission der Franziskaner (OFMCap.), *Kasita-Erklärung*, in ite, 1970. *ite Kurznachrichten:*, in ite, 1967.

[20] Fidelis Stöckli, *Alle haben ihre Sorgen*, in ite, 1968. Also in Walbert Bühlmann, *Überraschungen meines Lebens*, 1994, p. 87.

[21] BAR E2200.83(B) 1990/26 111.31: TEC Catholic Secretariat, *News Bulletin: President Nyerere: Church for social justice*. On Africanization in the local Church see: PADSM Box 17 - Mahenge 5: P.Gusti Brühwiler, *Mkutano wa tarafa ya Kwiro [10.08.1970]*.

[22] PA Widmer Edgar Widmer, *Medizinische Entwicklungshilfe aus schweizerischer Sicht [paper presented 9.3.1974 at Schweizerische Verband Diplomierter Krankenschwestern und Krankenpfleger, Zürich, Universitätsspital]*.

[23] BAR E2005(A) 1985/101 t.311 Tansania 22: R. Dannecker, *Letter to DftZ. Nairobi, 19.08.1974*; PADSM 155/5: Oskar Appert, *Letter, Ifakara 15.4.1973 to Provinzial*. PADSM 155/5: Deodat, *Letter P. Deodat, Kasita Seminary 23.4.1973 to Provinzial*.

[24] ASTIBS 6/1/2: Ifakara I/BSFEL: BSFEL, *Aktennotiz der Besprechung, 4.9.1974, im Verwaltungsgebäude Ciba-Geigy AG*. In addition, when user fees were dropped in 1976 the user numbers rose dramatically.

[25] Michael Jennings, *Surrogates of the State*, 2008.

[26] ".BAR E2005(A) 1985/101 t.751-339 Medicus Mundi bd 2: *Medicus Mundi Internationalis: General Assembly Aachen 1974*.

hospitals. Ifakara was soon to be one of these Designated District Hospitals.[27] For the national churches, Mwinyi held, continuing support to the hospitals was a question of paying tribute to the engagement of the missionaries.

A year later, when Mwinyi again was in Europe, the designation of St. Francis Hospital was discussed in depth in a meeting held in the hospital in Thalwil, where Edgar Widmer acted as the Medical Director.[28] Mission medical services in Africa at the time had come under critical fire for being too curative.[29] But for Ifakara, Mwinyi defended the medical legacy of the St. Francis Hospital, which was by far too large and too specialized and too curative for a District hospital:

> "Ifakara Hospital has an excellent reputation for good surgery and Government would not like to reduce this reputation. There has to be a good surgeon there. Surgery in Ifakara is a full time job. The Government would welcome the increase of number of doctors at the hospital. Government itself foresees a DMO for Public Health matters of the district. In the new Kilombero district Ifakara Hospital should become the Designated District Hospital, if authorities agree. [...] District Hospitals [...] supervise Health Centers, Dispensaries, and Sanitary Posts of a whole District and organize Public Health Activities. This additional task could in our case be a matter of the DMO."[30]

When Dr. Appert reminded Mwinyi that with such a strategy the hospital would remain dependent on international money and medical experts, Mwinyi acknowledged that this was exactly what he wished would happen. The St. Francis Mission Hospital became a Designated District Hospital on June first 1976.[31]

Mwinyi's approach to the integration of the St. Francis Hospital into the national health system started a most interesting institutional dynamic which cannot be discussed here in detail – it would be the subject matter of another book. Sitting squarely within the framework of the health system policy in Tanzania as it existed on paper, and thus also somewhat in contradiction to the international standards for rural health care provision, St. Francis hospital was to continue along a rugged trajectory as a mission hospital in need of transformation. Explicitly building on the missionary foundations, Mwinyi expected the international network to provide for curative quality medicine. The problem was that this put the hospital up against the policies of the non-missionary funding bodies on which the hospital had to draw.[32]

The Ministry of Health successfully kept the Swiss in the hospital. The integration opened a door for a large-scale and long-term financial engagement of the Swiss government

[27] T. W. J. Schulpen, *Integration of Church and Government Services*, 1975.
[28] PA Widmer & PAL & BAR Ordner "MMI Rüschlikon 1975" & Sch 1060.6 & E2005(A) 1991/16 t.311 - Tansania 22: Per Schellenberg et al., *Minutes about the Ifakara round table discussion held during the annual Meeting of Medicus Mundi International, Rüschlikon 1975*.
[29] O Akerele et al., *évolution*, in Chronique OMS, 1976. Reinward Bastian, *Kirchliche Gesundheitsarbeit auf evangelischer Seite*, 2011. p. 27 Socrates Litsios, *Christian Medical Commission*, in American Journal of Public Health, 2004.
[30] PA Widmer & PAL & BAR Ordner "MMI Rüschlikon 1975" & Sch 1060.6 & E2005(A) 1991/16 t.311 - Tansania 22: Per Schellenberg et al., *Minutes about the Ifakara round table discussion held during the annual Meeting of Medicus Mundi International, Rüschlikon 1975*.
[31] PAL Sch 1060.5: *Spital Ifakara - 'wird' 'Designated hopsital'. Notes of a meeting in Luzern, 11.09.1976.*
[32] PA Widmer DEH, *Richtlinien für medizinische Entwicklungszusammenarbeit: Grundlagen, Ziele und Mittel [t.024-4 - ZN/hj, Bern 20.01.1975]*.

development cooperation service SDC. Although the placing of a separate District Medical Officer practically cut St. Francis Hospital from an engagement in public health in the district, the hospital would eventually secure substantial funds from Swiss Development Cooperation – partly as a result of a review on its good integration into the national system and the good preventive medicine provided by the specialists on the staff of the hospital.[33] In 1977 the evaluators considered that preventive medicine also "includes curative services (prevention at the third level) [and that...] the hospital work may also include preventive measures (education)."[34] The general tonality of the evaluation was that in Kilombero health services were comparably good and catered for a larger section of the population, mostly because of the St. Francis Hospital. This evaluation was partly responsible for the rescue of the hospital from sinking in a large-scale financial crisis resulting from the integration – an obvious crisis which Appert, who by now had left the hospital, had predicted.[35]

The hospital survived thanks to a complex combination of institutional factors: in its past trajectory it had acquired the organizational capacity to provide good medical care, and it had established a very strong network. Based on this past, the hospital could now engage actively in new debates about preventive and community oriented medicine and about the integration of African staff at all levels of the hospital. This debate showed that the hospital sector was worthy of an engagement in Development terms.

St. Francis hospital now itself became the object of an intervention. The local Diocese lacked the capacity to steer such a large hospital. In 1984 a report of the Swiss Development Cooperation services noted.

> "All in all, my visit with […] to SFH confirmed the impression that SFH is a well run hospital but that things may not continue as heretofore indefinitely [...] How can these issues be raised? For the time being, I do not think that there is sufficient impetus locally to take them up seriously. [.. ] some sort of outside intervention of this kind [a consultant] is indispensable."[36]

This transformation process was sailing under the name of "Africanization". Africanization has a long history linked to the politics of colonial administration and decolonisation.[37] In the context of the St. Francis Hospital, however, an independent definition of Africanization evolved. Africanization was not only about the takeover by nationals from

[33] ASML/PAL R3T6O2quer/PAL Sch 1060.5: K Gyr, *Swiss -Tanzanian Joint Evaluation fo Swiss Cooperation to Tanzania Health Projects. Public Health Aspects, 04.1987*. PAL & PADSM Sch 1060.3 & 155/3: Medicus Mundi et al., *Letter to DEH, Luzern, 04.02.1978: SFH: Übernahme der Kosten für die Aufstockung der Arztsaläre und Einsatzkosten im allgemeinen*. SDC had supported staff members before. For doctors, including Dr. Schellenberg see: BAR E2005(A) 1985/101 t.751-7(7): Hans Studer, *Letter SKMV to DftZ Luzern 04.07.1970*. BAR E2005(A) 1985/101 t.751-7(7): DftZ et al., *Letter to SKMV. Bern 03.05.1970*.

[34] ASML/PAL R3T6O2quer/PAL Sch 1060.5: K Gyr, *Swiss -Tanzanian Joint Evaluation fo Swiss Cooperation to Tanzania Health Projects. Public Health Aspects, 04.1987*.

[35] PAL Sch 1060.3: Fidelis Stöckli, *Letter to E.Widmer. 12.04.1977*.

[36] BAR E2025(A) 1993/130 t.311 Tansania 22: Benedikt Dolf, *Appendix 2 Health Ifakara. ca 01.05.1984*.

[37] Eckert, *Herrschen und Verwalten: Afrikanische Bürokraten, staatliche Ordnung und Politik in Tanzania, 1920-1970*. pp. 80, 170f, 226.

expatriate staff. It was also an issue of standards in medicine considered appropriate and sustainable under local 'rural conditions'. And, not least, it was also a matter of "democratization in the sense of the transfer of effective and necessary institutions to locally acknowledged and rooted corporations."[38] All these medical and ownership issues mixed into the project of 'Africanization'. For almost ten years, it was held that Africanization (now termed 'Tanzanisation' and 'Diocesezation'),

> "should never mean decline in the quality of hospital management and care; hence careful selection and adequate preparation is crucial. Being a mission hospital [sic!] the Diocese may like to have some key positions occupied by diocesan staff, for example Hospital administrator, matron, hospital technician and a number of nursing officers."[39]

It can be argued that the debates spurred by Africanization set up a tension within the institution which was responsible for the survival of the institution because they provided reasons for continued support in, at the least, accompanying its transformation. St. Francis Hospital remained in the portfolio of the Swiss Development Cooperation as an exceptional case and, for most of the time, was probably the only secondary level health unit to receive substantial financial support towards its running cost. This dynamic never really collapsed until the mid 1990s.[40]

It soon showed that within these fields of national health system policies and international standards for medicine in developing countries, the hospital could act with a degree of freedom: the medical director defended the autonomy of Church health policies in 1982: "Even after their designation hospitals can stick to Christian caritas as the base for their services."[41] The conflict was partly about birth control[42] but it was also based on an ethical argument linked to the great popular demand for curative services:

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[38] *Editorial*, in Bulletin Medicus Mundi Schweiz, 1983.

[39] BAR E2025(A) 2002/145 t.311 Tansania 22 *Long Term Concept SFDDH Ifakara. Final Report DSM November 1992 [20.11.1992]*.

[40] Archive IHI Folder SFDDH: SFH, *Extracts from SFDDH Long Term Concept Workshop, 21.07.1997-24.07.1997*; BAR E2025(A) 2002/145 t.311 Tansania 22 *Long Term Concept SFDDH Ifakara. Final Report DSM November 1992 [20.11.1992]*. ASML & BAR E2200.83(B) 1999/351 771.22.8: Wolfram Moll, *Stellungnahme zur Internen Evaluation des SFH Ifakara 1983 (Dr. Ch. Hess)*; ASML Schachtel_A4_braun/"ganz alte Berichte versch. Länder/SFH Evaluation Hess": Christian Hess, *SKMV: Interne Evaluation des SFH von Dr. Christian Hess, Luzern 01.12.1983 [inkl. Ergänzender Anhang für internen Gebrauch]*. Documents on the support of DftZ/DEH/DEZA to the St. Francis Hospital are in different accessions (E2005/E2025/E2026) usually under the signatures t.311 Tanzania 22 or t. 541-7(7) SKMV/Solidarmed. PA Schellenberg Folder Nutrition Promotion Muttermilch Per Schellenberg, *Staatliche und private medizinische Entwicklungshilfe der Schweiz [Hauptvortrag 68. Jahresversammlung der Schweiz. Gesell. für Radiologie und Nuklearmedizin, Luzern, 22.05.1981*.

[41] ASML R1T1AS3: Wolfram Moll, *Letter to SKMV. Ifakara 21.05.1985*; ASML R3T6O6: Wolfram Moll, *Letter M. and H. Portmann, Ifakara 29.11.1982 [Ausschnitte]*; ASML & BAR E2200.83(B) 1999/351 771.22.8: Wolfram Moll, *Stellungnahme zur Internen Evaluation des SFH Ifakara 1983 (Dr. Ch. Hess)*.

[42] ASML R1T1S1O4: Rudolf Lehnhoff, *Final Report and Considerations (SFH, Tanzania, 01.08.1983-30.09.1986)*, p.15.. For a women doctor's view: ASML R3T1S1O1: Martine Robyn-Wagnières et al., *Rapport personnel concernant notre engagement à Ifakara, Tanzanie (5.1982-4.1984)*.. With the argument of overpopulation: ASML R3T1S1O1: Walter Schweizer, *Schlussbericht (SFH 1982-1983)*. sda, *St. Francis-Spital in Ifakara: Kirche gegen staatliche Gesundheitspolitik?*, Höfner Volksblatt, 29.10.1985. ASML & BAR E2200.83(B) 1999/351 771.22.8: Wolfram Moll, *Stellungnahme zur Internen Evaluation des SFH Ifakara 1983 (Dr. Ch. Hess)*, pp81-82. ASML R3T6O7: Eric Burnier, *Letter to C.Hess, Ifakara*

> "of course it is logical that it is better to control mosquitoes, than to treat malaria [...but] if someone who needs curative services finally has worked from the periphery through the referral system into SFH, he needs and should be entitled to good curative care. Taking scarce expatriate SFH staff for PHC activities in the district may easily destroy SFH services, without gaining anything in terms of better PHC care."[43]

Such popular demand was matter of concern to those who saw a need for a rapid transformation, towards a more district health oriented approach and who realized that they had come to work at a hospital which was in their eyes not geared towards developmentalist medicine.[44] For them:

> "The services of the hospital are too aligned with the desires of the population (elective surgery, dispensing expensive and often not indicated drugs as a placebo or because requested by patients) instead of real needs (infectious diseases, nutritional services)."[45]

The Medical Director was obviously irritated by the demands for swifter Africanization, and declared: "We are not going to abandon the hospital and march into the villages..."[46] Nonetheless, he drove the establishment of a Diocesan Health Board and a Community Health Department in the hospital, which was to link with the mission dispensaries all over Ulanga, and to provide medical supervision and training for the staff working in these dispensaries.[47]

The Community Health Department (CHD was the institutionalization of an older tradition of 'dispensary tours'. The institutional tradition of these tours, as far as the mission goes, was that the tours were not actually implemented. Since at least the early 1960s, the medical directors may well have been asked by Bishop Edgar Maranta to visit the mission dispensaries. In general, however, they had not much time for this activity.[48] In 1978, in 1981 and again from 1984 the 'dispensary tours' were again and again re-started, but collapsed again.[49] The CHD to some degree succeeded in changing this by the firm institutionalization of this field of activity.

The CHD also was a frontline department when it came to Africanization. From the beginning it was largely in the hands of African doctors. It was a difficult career choice to take: you would have to downgrade on the professional ladder of medicine, in order to climb the professional ladder of cosmopolitan development experts."[50]

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*27.06.1986*. The working consensus from mid-1985 was a family planning unit just outside the hospital, , and then in containers bought from the STIFL. Interivews with F. Lwilla and with Mama Lubomba.

[43] ASML R1T1S1O4: Rudolf Lehnhoff, *Final Report and Considerations (SFH, Tanzania, 01.08.1983-30.09.1986)*.

[44] ASTIBS & PADSM 6/2/6 "S.Francis Hospital" & 155/3: C.A Steiner, *Rapport d'activités 1975-1976*, p.6. See also ASML: Andreas Wirz, *SFH, Tanzania. Evaluation 1980 zuhanden der DEH und des SKMV*.

[45] ASML R3T1S1O3: Brigitte Brändli, *Schlussbericht (SFH, Tanzania 01.04.1978-30.06.1980)*.

[46] ASML R3T6O6: Wolfram Moll, *Letter M. and H. Portmann, Ifakara 29.11.1982 [Ausschnitte]*.

[47] In 1981 STIFL director Marcel Tanner started to cooperate with the hospital doctors in a project called Kilombero Health Research. The role of the hospital was defined as „collaboration in view of applied PHC"PADSM Box 156 SFH 7: St.Francis Hospital Ifakara et al., *Jahresbericht 1982*.

[48] PADSM Box 155 SFH 1 -1-: Edgar Widmer, *Medizinische[?] Aussenstationen in der Diocese Mahenge. Besuchsbericht vom 11.1964*. TNA 461 16/8: *"Tribal Dispensaries"*.

[49] ASML: Andreas Wirz, *SFH, Tanzania. Evaluation 1980 zuhanden der DEH und des SKMV*. ASML R3T1S1O3: Caspar Brunner, *Schlussbericht (SFH, Tanzania 04.1981-12.1981)*; ASML R1T1AS3: Wolfram Moll, *Letter W.Moll, Ifakara 21.05.1985 to SKMV*.

[50] ASML R3T5O8: Ifakara Verein, *Protokoll der Vorstandssitzung des IfakaraVereins vom 09.01.1985, Olten*. Interviews with F. Lwilla and George Simba. ASML R3T1S1O1: Martine Robyn-Wagnières et al., *Rapport personnel concernant notre engagement à Ifakara, Tanzanie (5.1982-4.1984)*, p.4.

Nonetheless, Moll's successor was frustrated in his attempts to launch Primary Health Care:

> "PHC was a most disappointing issue [... ] I spent a lot of time [...] to explain and discuss the subject with the Bishop, with the District authorities, and their staffs. Everybody is very much interested [...] but there is absolutely no action taken so far. [...] As an expatriate I'm not in a position to push forward PHC activities outside of the field I'm responsible of (SFH and related dispensaries) if I cannot work hand in hand with the DMO and his staff. PHC should not be some kind of *'Wazungu* project' [Expatriate/European project] I think."[51]

Ten years later, the situation had hardly changed. When the new flagship of Swiss health sector activity in Kilombero (the KDHS, the Kilombero District Health Support) held a workshop with local health workers, the PHC credo of community participation was not well received by the Tanzanians: "the idea of community participation as it had been discussed in the planning workshop was a concept not well understood, and even objected, by most of the participants."[52]

There was little actual interest in "Africanization" in the general population in Ulanga. For an ordinary citizen in Ulanga, there was not much to immediately gain from Development if it consisted of being thrown back onto your own meagre (and less modern) resources. The 'success' of a development project on the receiver's side is not necessarily measured in de-connectedness to international structures of support and solidarity. On the contrary, especially in the field of social services, receivers knew that sustainability under the precarious conditions of the Tanzanian crisis of the 1980s meant nothing but poor services. Quite on the contrary, there was large and growing demand for the hospital's good quality medical services – delivered at practically no cost to the patients with the help of international funding. The in-patient numbers had risen from 4,000 in 1966 to almost over 11,500 in 1986. In the same period, births at the hospital had also risen, from 850 in 1966 to 2240 in 1986.[53]

One can deduce local expectations from the growth of paediatric in-patient department numbers. In the mid 1980s, in-patient numbers were rising in general, but they did so especially in the paediatrics department where, within three years, the numbers tripled.[54] The policy of the Bishop in the 1990s is telling, too. He tried to answer the local 'demand' by appointing a surgeon who brought his wife to Ifakara who was a paediatrician.[55] It was clear that the Bishop had to provide in this core area of trust in the Church health services, that of maternal and child health and welfare services. Maternal care was highly regarded by villagers, but was perceived as poor

[51] ASML R3T6O7: Eric Burnier, *Letter to C.Hess, Ifakara 27.06.1986*.
[52] BAR E2026(A) 2005/9 t.311 Tansania 22 Bd 1 SFH: Markus Frei, *Fax to A. Buluba, SDC. Luzern 06.11.1994*.
[53] I have looked at all annual reports and established the numbers on the basis of the complete series of annual reports, copies in my personal archive.
[54] ASML R3T6O7/ Tanzania Ifakara Official Letters II Juli 82-Okt 90: C. Hess, *Letter C.Hess to E.Burnier, Ebertswil 28.03.1986*.
[55] Frei, M. (1990). Lettter M.Frei to SM, ifakara 15.06.1990. ASML, R3T6O7/ Tanzania Ifakara Official Letters II Juli 82-Okt 90.

quality in the early 1990s.[56] This is an example of an impressive feedback of the missionary legacy. The feminization of health care and the medicalization of childbirth and child-rearing had been started as a core practice of modern medicine in Ifakara in the 1930s. Now it was a quickly growing and popular service, quite in line with current global health policies.[57]

## Dispensary Services and the Missionary Pioneer

We have already seen in Chapter 5 how these practices have been constructed and that these were actually the roots of the St. Francis Hospital going back to Sr. Arnolda's work at the mission dispensary. The Baldegg sisters had continued their medical work in the dispensaries outside the hospital sector in the hands of the academic doctors. Now, in the early 1970s, the Baldegg sisters however faced a situation of a future with a shortage of young sisters, and a declining weight of their position in Diocese. By that time the Diocese of Mahenge ran 18 dispensaries of varying quality, with a total staff of about 50 health workers, of whom six were qualified Baldegg sisters.[58] When Sr. Erika, a teacher, reflected on the vision of the future engagement of the sisters, she focused all the more on their tradition as transnational pioneers:

> "The sisters working in health care should go deeper into the 'bush' to start pioneering work as they have done many times before. African sisters will follow, but with the help of our friends at home, it is easier for us to start something new."[59]

As they went out, the sisters would also take with them the ideas and teachings and skills of *maendeleo*.

The practices in the dispensaries still resembled the missionary tradition. The general services at the dispensaries in the 1960s and later included cheap or even free medical treatment for the poor, cyclical anti-famine measures, as well as continuous support with food given to mothers and their children when they showed at the clinics. Syrups, pills and injections against anaemia were also highly popular since the 1960s. In addition, midwifery remained a core activity in all the dispensaries, and some even had specific maternity units. More than 1,000 children were born in mission dispensaries every year in the early 1970s.[60]

What is striking is that the sisters only marginally profited from the State Development Cooperation funds, although their dispensaries came very close to the policy model of the health

[56] Lucy Gilson et al., *Community Satisfaction*, in Social Science and Medicine, 1994, p.779. In our interviews, we have recorded a lot of nostalgic feelings about the earlier times, when the missionaries were still providing these services. Similarly: Adeline Masquelier, *Behind the Dispensary's Prosperous Façade*, in Public Culture, 2001, pp. 270, 274, 279.
[57] Critically reflecting this is even: World Health Organization, *Primary Health Care Now More Than Ever*, 2008, p. 9.
[58] DAK folder 'hospital ifakara' in Acc. Secretary na Serikali Shelf I & III: Rüdiger Finger, *Letter to P. Iteka. Ifakara 00.03.1972*.
[59] Schwester Erika Lischer, *50 Jahre Baldeggerschwestern in Tansania 1921-1971 (manuscript)*, (PADSM/Institut Baldegg, 1971), p. 67.
[60] ASML: R2T1S2blauO2 Afrika. [Briefe im Zusammenhang mit Vergabungen an diverse Stationen].

centre. In fact, in Mtimbira, a Baldegg sister was in charge of a Government health unit.[61] Like true barefoot doctors, or community health workers for whom the Tanzanian approach set a model, the sisters "went on foot for hours to visit people in the vicinity and teach them how to prevent disease", or they paid local workers to build latrines at the homes of elderly people.[62]

Sr. Pankratia even engaged critically in the debates about the politics of the transition at St. Francis Hospital:

> "we too have a hospital [St. Francis Hospital] which is always being extended; another operation theatre, another modern machine etc. But how does that help the people? Wouldn't it be better to teach people how to prevent disease? Wouldn't this create a more sustained change than a prestigious hospital, which no one will have the capacity to continue after we've left?"[63]

In the early 1970s, in pursuit of the pioneer tradition, Sr. Pankratia moved to Mofu where the Mission had established a new dispensary and maternity unit in the late 1960s. She had subscribed to the idea of the development of Tanzania, although she remained critical about the actual implementation of villagization.[64] At the same time, she experienced the reality of the missionary engagement in secular Development. When she taught the local community about hygiene and good nutrition, the religious sister was challenged by locals: "what is this with the *chakula bora* [better nutrition]. It is God who gives health to this child."[65]

This is certainly an explicit example of the missionary legacy as one that was engaging in the secular and material dimension of Development and even more so for the persistence of Kulturarbeit in the Mission. Additionally, the work of the Baldegg sisters in the dispensaries again represents that the institutional set-up of the religious organization could also hinder the medical side of health institutions (see Chapter6). Baldegg sisters have not only nursed the sick and propelled the professionalization of nursing. They have also been experts in the diagnosis and treatment of patients much as if they were 'doctors' rather than nurses. The sisters I interviewed were aware of their medical role with some pride and defended their professional turf. In addition, there was some sort of congregational politics involved in the dispensaries too. It seems that Baldegg sisters would not easily accept that laic sisters as co-workers in their dispensaries.[66] And although they had worked alongside Africans in good working relationships, they did not easily entrust their institutions to them. In a personal conversation with a person involved in the dispensary at the Mission in Ruaha after the Baldegg sisters had left, I was told

[61] *Interview with Sr. Josephata Schürmann, Dar es Salaam, 31.01.2009*; DAK Box Mtimbira: Nicas MGR Kipengele, *Mkataba. Kukabidhi hospitali ya Mtimbira, R.C. Mission Serikalini*.
[62] ASML R2T1S2blauO2 Afrika. Tanzania.../Kwiro, Mahenge, Mofu: Sr. Pankratia Stumpf, *Letter to Studer. Kwiro, 26.06.1971*. Kris Heggenhougen et al., *Community Health Workers*, 1987.
[63] ASML R2T1S2blauO2 Afrika. Tanzania.../Kwiro, Mahenge, Mofu: Sr. Pankratia Stumpf, *Letter to SKMV. [date? received 22.10.1973]*.
[64] Sr. Pankratia Stumpf, *Chronik von Mofu 1972-1982*, (1993).
[65] ASML R2T1S2blauO2 Afrika. Tanzania.../Kwiro, Mahenge, Mofu: Sr. Pankratia Stumpf, *Letter to Güntert. Mofu 17.01.1975*.
[66] ASML R2T1S2blauO2 Afrika. Tanzania.../Ruaha, Sali: Sr. M. Clementina, *Letter to SKMV, Ruaha 18.09.1966 incl document "Ruaha Maternity"*.

about the problems this person encountered with the missionary legacy. A major issue was the lack of a transnational network of donors. The people coming to the dispensary had begged the new person to continue the material flow that the Baldegg sister had sustained: soap, clothing, food. As she could not provide all these things, she found her position very hard: "it's like with a dog, you show him the meat, and then you take it away".[67]

## Trajectory and Entanglement

This episode explains much about some of the issues that we have raised at the beginning of this thesis. Together with the stories about the demand at the St. Francis hospital for social services and welfare from the global domain, it tells us about the unequal ways in which the 'developers' and the 'developed' were organized in the course of the 20th century, and how important the representations of modernity and the translocal connections are. The historical links have tied Ulanga to Switzerland from colonial times until today through colonial and post-colonial ties of solidarity. Our focus has been on the changing level or pitch of these entanglements ["Verflechtungsgrade" in German] across social and cultural worlds and how they have configured a cosmopolitan medicine.[68] Currently Swiss Development cooperation is back in St. Francis Hospital with a multimillion Dollars rehabilitation project.[69]

The health system of Ulanga is the product of such an entangled historical process in which the Mission and Church services were a central pillar. This thesis has contributed examples to the knowledge about the history of the health units which made up the health system in the past.[70] Beyond that, we followed an argument that the historical role of missionary institutions in the health system goes beyond the introduction of a series of services into the medical marketplace. We have described how the Mission's medical services framed the practices of *dawa ya kisasa* – modern, cosmopolitan medicine – in the region. In and around missionary health institutions, moral economies and knowledge about well-being and medicine were articulated. We have seen how the Capuchin Missions via its medical branch got involved in the configuration of pastoral power and in the coming of Development in Ulanga. Throughout the chapters we have seen how health had become a field for interventions which addressed the 'rural' as a specific location.

The past trajectories of these institutions are relevant because they structured the future path of health care provision and practices in the field of development. These trajectories or paths however were not straight and unbroken. Still, the concluding examples have again

[67] Anonymous, Ifakara 28.05.2010.
[68] Hubertus Büschel et al., *Entwicklungswelten - Einleitung*, 2009, p. 20.
[69] http://www.swiss-cooperation.admin.ch/tanzania/en/Welcome_to_the_Swiss_Cooperation_Office_in_Tanzania/ressources/resource_en_224358.pdf
[70] James White et al., *Private Health Sector Assessment*, 2013, p. 24.: suggested "a new view of the Tanzania health system" which includes the private actors.

pointed to the fact that traditional medical practices of the mission, namely basic health care, moved to the centre of and interacted with rural medical policies for developing countries. Not least, it has underlined our argument that the long-term engagement of the Mission has produced 'global' institutions where local engagement created practices that structured the knowledge of Development.

# Resources

## Interviews

Not all of the interviewees have been quoted in the text. They have nevertheless formed my understanding of the history and legacy of the Catholic Mission and its medical work in Ulanga. Without small exceptions these interviews are all recorded digitially in mp3 and available in my private archive

Phemy Muhaku, Zacharias Likopa, George Mwambeta and Jonathan Chitalula have worked with me for most of the interviews conducted in Ifakara, Ruaha and Mahenge.

During 4 days in April 2010 we recorded in Ruaha interviews on the history of the dispensaries in Ruaha and Chirombola. Amongst those I spoke too were: Halahala, Omary Kainama; Mganga, Jeremia Julian; Niyambaga, Sixberth; Tayari, Apolonia Ostai, Tinyela /Tinyala, Lukas.

In May 2010 Phemy Muhaku and I conducted 5 Focus Group Discussions with elderly people from Ifakara. Amongst these were: Chamamba, Saidi; Lifulana Juma; Liseki, Miriam; Lubiki, Abdu Mohammedi; Lumbanga, Saidi; Mama Makwasinga; Binti Masheyo; Mfalimbena, Saidi; Mfeite, Clarence Mikaeli; Mama Mitalula; Mng'etu, Aido Raffaeli; Mpalangondo, Ramadhani Omari; Msaraka, Casian; Binti Msomoka; Mtengela, Amina; Ngonimtela, Mariam; Ngalyoma, Brandina; Ngalyoma; Michael; Mwitende, Hadjia; Binti Ruvu; Timbanga, Athumani Mohammedi. I am sorry that the names of the members of one Focus Group are lost.

| | | |
|---|---|---|
| Allenspach, Sr. Bernardina, Dr. | 02.03.2009 | DSM |
| Birauli, Jerôme | 22.05.2010 | Ifakara |
| Diethelm, Rolf, Dr. | 17.02.2010 | Altdorf |
| Eponda, Monica S. | 19.05.2010 | Mahenge |
| Female local healer | 12.05.2010 | Ifakara |
| Freyvogel, Thierry, Prof. Dr. | 09.06.2008 | Arisdorf |
| Gasche, Sr. Ruth | 28.02.2009; 23.04.2010 | DSM |
| Haridas, Manu | 03.04.2009 | Ifakara |
| Inauen, P. Meinhard | 28.01.2009 | DSM |
| Kahigwa, Elizeus, Dr. | 06.02.2009 | DSM |
| Kasigwa, George, Dr. | 03.04.2009 | Ifakara |
| Kibatala, Pascience, Dr. | 04.06.2010 | DSM |
| Kilumanga, Iddy Ali | 22.05.2010 | Ifakara |
| Lihimba, Adam | 12.04.2009; 06.05.2010 | Ifakara |

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|---|---|---|
| Limbaira, Elias | 26.05.2010 | Ifakara |
| Lubomba, Grace | 28.05.2010 | Ifakara |
| Lungombe, Ally S.J. | 19.05.2010 | Mahenge |
| Lwilla, Fred, Dr. | 23.02.2009 | DSM |
| Mapunda, John | 13.05.2010 | Ifakara |
| Massawe, Sr. Immaculata | 04.04.2009 | Ifakara |
| Mathis, Br. Franz | 16.12.2010 | Luzern |
| Mboya, Dominick, Dr. | 11.04.2009 | Ifakara |
| Mdai, Callistus, Vicar General | 16.02.2009 | Kwiro |
| Mgaya, Mama | 25.05.2010 | Ifakara |
| Mkope, Fred | 27.05.2010 | Ifakara |
| Mkwilli, Esther | 13.02.2009; 08.04.2009; 28.05.2010 | Ifakara |
| Moshi, Jeremia, Dr. | 07.04.2009 | Ifakara |
| Mpombo, Lea | 24.05.2010 | Ifakara |
| Mtemanyenja, Bartholomäus | 14.04.2009 | Ifakara |
| Mtengela, Mama | 25.05.2010 | Ifakara |
| Muheteli, Serafin | 06.04.2009 | Ifakara |
| Ngidula, Stella, Matron | 08.04.2009 | Ifakara |
| Njimbali, Gerald Gabriel | 17.05.2010 | Mwaya |
| Njohole, Faruz | 12.05.2010 | Ifakara |
| Ngomaholo, Susanna | 12.04.2009; 07.05.2010 | Ifakara |
| Pachow Germana | 28.05.2010 | Ifakara |
| Schöpf, Carl, Dr. | 23.07.2008 – 25.07.2008 | Zams |
| Schöpf, Irmengard | 25.07.2008 | Zams |
| Schürmann, Sr. Josephata, | 31.01.2009 | DSM |
| Shubis, Kafuruki, Dr. | 27.02.2009 | Bagamoyo |
| Simba, George | 06.05.2010 | Ifakara |
| Sister Radegunda | 02.04.2009 | Ifakara |
| Sobotkiewicz, Jiri, Dr. | 25.01.2010 | Allschwil |
| Spierings, "Mama" Peta | 01.02.2009 | DSM |
| Steiner, Edelwald, Ofmcap, Dr. | 02.12.2010 | Luzern |
| Tanner, Marcel, Prof. Dr. | 30.05.2009 | Basel |
| Ulaya, Adrian | 06.04.2009 | Ifakara |
| Von Moos, Br Edwin (von Moos) | 12.08.2008 | Brig |
| Wicki, Sr. Maria Paula | 26.01.2010 | Baldegg |
| Widmer, Edgar, Dr. | 23.10.2008;27.10.2008 | Thalwil |
| Zanolli, Noa, Dr. | 12.05.2009 | Bern |

## Archives

| | |
|---|---|
| AMMS | Archiv Medicus Mundi, Basel |
| ASML | Archive Solidarmed, Luzern |
| ASTIBS | Archiv Schweizerisches Tropeninstitut, Basel |
| BAR | Schweizerisches Bundesarchiv, Bern |
| DAK | Diocesan Archives, Kwiro |
| IHI | Archives of Ifakara Health Institute, Ifakara |
| IAB | Institutsarchiv, Baldegg |
| MIW | Missionsärztliches Institut, Würzburg |
| PA [N.N.] | Holdings at a Private Archive/Collection (e.g. PA Diethelm) |
| PADSM | Provincial Archives (Capuchins), Dar es Salaam |
| PAL | Provinz-Archiv (der Schweizer Kapuziner Provinz), Luzern |
| Parish [N.] | Holdings at a particular Parish (e.g. Parish Ruaha) |
| PSKO | Prokura der Schweizer Kapuziner, Olten |
| STALU | Staatsarchiv (des Kantons) Luzern, Luzern |
| TNA | Tanzanian National Archives, Dar es Salaam |

## Series

These publication series have been consulted in the full series, for the period of existence or at least for the years 1920 to 1980:

- Jahresbericht der Schweizer Kapuziner in Afrika, Olten/Luzern
- Missionsbote der Schweizer Kapuziner, Olten/Luzern
- Missionsärztliche Caritas, Luzern
- Schweizerisches Katholisches Missionsjahrbuch, Freiburg
- Seraphisches Weltapostolat des Hl. Franz v. Assisi (up to 1939 only), Altötting

not publicly available:

- Providentia [internal newsletter of Baldegg congregation]

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Lebenslauf Marcel Dreier

Ich bin am 10. März 1972 als Sohn von Heidi Dreier-Walker und German Dreier in Luzern zur Welt gekommen. Nach Primarschulen in Horw und der Maturität an der Kantonsschule Alpenquai in Luzern studierte ich ab 1992 Neuere Allgemeine Geschichte, Schweizer Geschichte, Ethnologie und Soziologie an der Universität Basel. 2003 schloss ich bei Prof. Josef Mooser mit dem Lizentiat und einer Arbeit über die antiimperialistische Solidaritätsbewegung in der Schweiz während den 1970er Jahren ab.
2007 begann ich auf Anregung von Prof. Patrick Harries und Prof. Marcel Tanner an der Universität Basel und dann bald als Teil der Graduate School of History dieser Universität mit der Forschungsarbeit an der vorliegenden Dissertation im Rahmen eines hauptsächlich vom Schweizerischen Nationalfonds geförderten Projektes zur Geschichte der ländlichen Gesundheitssysteme in Afrika. Die mündlichen Prüfungen im Fach Neuere Allgemeine Geschichte legte ich am 23. Januar 2015 ab. Zur Zeit des Druckes dieser Dissertation leite ich seit fünf Jahren den fepa, Fonds für Entwicklung und Partnerschaft in Afrika.